THE INFLUENCE OF CLIENT SOCIOECONOMIC STATUS
ON COUNSELORS’ ATTRIBUTIONAL BIASES
AND OBJECTIVE COUNTERTRANSFERENCE REACTIONS

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THE INFLUENCE OF CLIENT SOCIOECONOMIC STATUS
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ABSTRACT

The present study examined the influence of client socioeconomic status (SES) on counselors’ cognitive (attributional biases) and emotional (objective countertransference) reactions. The purpose of the study was to better understand how counselors respond cognitively and emotionally to clients of different SES backgrounds when other demographic and clinical characteristics remain unchanged. A national sample of 141 participants included licensed professional counselors, marriage and family counselors, social workers, counseling psychologists, addiction counselors and counselor-trainees. Data was collected through an internet survey using an analogue-style design employing a client video simulation of the same actor portraying a higher versus lower SES client with the same clinical presentation. Attributional bias was measured by the Clinical Attribution Scale (CAS) (Chen, Froehle, & Morran, 1997) and objective countertransference was measured by the Impact Message Inventory-Circumplex (Brief Version) (IMI-C) (Kiesler & Schmidt, 2006). ANOVA results revealed no significant main effect for participant attributional bias for the lower versus higher SES client simulation. MANOVA results for the IMI-C subscales revealed a statistically significant difference on the Dominant IMI-C subscale. Participants viewing the higher SES client simulation rated the client as interpersonally impacting them in a dominant way compared to those viewing the lower SES client. Using a clinical judgment questionnaire, exploratory follow-up t-tests revealed that participants viewing the higher SES client
believed he manifested significantly less severe life problems than the lower SES client. Findings indicate that client SES can impact counselor emotions (objective countertransference) and clinical judgments. Recommendations for counselor education and supervision, counseling theory, and future research are summarized.
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CHAPTER I

INTRODUCTION

Overview

Socioeconomic status (SES) is considered to be a characteristic associated with client diversity (D’Andrea & Daniels, 2001). Yet, its cultural significance has not been adequately considered in mental health research (Lam & Sue, 2001; Liu, 2001). For example, despite early assertions of counselor bias related to client SES (Abramowitz & Dokecki, 1977), little empirical research has examined how SES impacts the therapeutic exchange between counselor and client (Liu, Soleck, Hopps, Dunston, & Pickett, Jr., 2004). Therefore, the present study attempted to better understand how counselors respond cognitively and emotionally to clients of different SES backgrounds.

“Lazy,” “unmotivated,” “angry,” “stupid,” “unreliable,” “impulsive,” and “not suitable for insight-oriented therapy” (Franklin, 1986; Javier, Herron, & Yanos, 1995; Lott, 2002; Smith, 2005) are phrases that represent just a few expressions capturing the attitudes of some mental health professionals working with clients from a lower SES background. Some counselors may believe that clients of a lower SES background are to blame for their problems and other counselors may feel sorry for them (Javier & Herron, 2002). Even the writer has felt some of these feelings and has observed similar attitudes of other fellow counselors, when working, first hand, with clients from lower SES backgrounds. Moreover, research from other professions (i.e., field of medicine) has
shown that SES impacts how professionals think about, and interact with clients (Woo, Ghorayeb, Lee, Sangha, & Richter, 2004). Yet, very little has been written in the mental health literature to help counselors to identify and confront their feelings and attitudes related to socioeconomic status differences. The present study focused on investigating whether SES influences counselors’ cognitive and emotional reactions toward clients.

Socioeconomic Status Defined

First, it is important to introduce the concept of SES and how it was defined in the present study. Most research studies and literature reviews have discussed concepts related to socioeconomic inequality in terms of SES and social class. However, there is not much agreement in how these two concepts are understood and differentiated. Traditionally, research has measured socioeconomic inequality in terms of education, occupation, or income (Wohlfarth & van den Brink, 1998). Some researchers understand these measurements of economic stratification to be objective indices associated with defining SES (Oakes & Rossi, 2003; Wohlfarth & van den Brink). However, other writers have argued that these indices do not account for the subjective qualities associated with the values, relationships to, and access to different socioeconomic groupings (Fouad & Brown, 1997; Liu, Ali, et al., 2004). Others have also pointed out the importance of considering the concept of personal control over productive assets and resources, a concept that has been traditionally associated with the definition of social class (Liu, Ali, et al.; Oakes & Rossi; Wohlfarth, 1997; Wohlfarth & van den Brink). Although more abstract status indicators such as control of resources and interpersonal social standing are recognized as an important aspect of socioeconomic inequality (Liu,
Ali, et al.; Liu, Soleck, et al., 2004; Oakes & Rossi), a consistent form of measurement to adequately stratify these subjective characteristics is lacking.

Due to the subjective nature of characteristics associated with SES and the difficulty researchers have had in operationalizing and empirically measuring this construct, the present study focused on concrete concepts related to SES, and how those characteristics (i.e., income level, education, and occupation) influenced counselors’ cognitive and emotional reactions. In the present study socioeconomic status was operationalized as an individual’s current combined financial (i.e., annual income), educational (i.e., years of formal education), and occupational (i.e., type and rank of paid employment) status relative to one’s broader social community.

Statement of Problem and Need for Study

SES may have the power to positively or negatively influence the therapeutic process between a counselor and client. The mental health field is in need of more research which recognizes SES as a cultural factor in client diversity. There is also a need to investigate the influence of SES on counselor bias, particularly as it relates to a counselor’s cognitive and emotional reactions to a client. For example, in the last decade multiculturalism has gained more attention in the research and training of mental health professionals. Race, gender, and SES are commonly listed as the three key multicultural aspects of client identity. Yet, SES continues to be the least researched multicultural construct compared to its counterparts (Lam & Sue, 2001; Liu, 2001; Zandy, 1996).

The following sub-sections discuss the problems generally associated with SES and counselor bias research, and describe the need for further study in this area. The first
section examines how SES has been operationalized in past mental health research. Next, a brief review of the findings from previous studies related to SES and counselor bias is provided, including problems associated with some of these studies. In addition, a review of the concepts of attributional bias and objective countertransference is presented, how they represent counselors’ cognitive and emotional reactions to clients, and how an examination of these two constructs will further advance research related to SES. Finally, how the present study has the potential to advance the counseling profession is discussed by not only recognizing SES as a client diversity characteristic, but also by identifying two forms of counselor reactions (attributional bias and objective countertransference) which have not been previously examined in the mental health research.

Measurement of Socioeconomic Status

The following section will review the problems associated with defining and measuring SES and it will also examine SES as a cultural construct.

*Lack of Conceptual Clarity*

There are several problems with past research conducted on SES and mental health, particularly as it relates to how SES has been defined and measured. The concept of SES lacks a conceptual clarity across various studies and also a consistent form of measurement (Liu, Ali, et al., 2004; Oakes & Rossi, 2003). In many cases, SES has been considered more as a demographic or descriptive label than as a cultural construct (Liu, Soleck, et al., 2004). This means it has been used to group individuals in terms of their income, occupation, educational level, and residential address (Hollingshead & Redlich,
1958). Yet, SES has not been consistently defined according to these groupings. Researchers have either created their own methods of categorizing individuals into SES groupings or relied on outdated ones (D’Andrea & Daniels, 2001). These inconsistent methods of stratifying SES have prevented the emergence of a clear definition of SES in research studies (Liu, 2001). They also assume “homogeneity,” ignoring the individual differences which may exist within each group (Liu).

**Socioeconomic Status as a Cultural Construct**

SES exists as a part of an individual’s identity (Liu, Soleck, et al., 2004), it effects how we perceive success in economic and social terms (Liu, Soleck, et al., 2004; Storek, 1997), it has the capacity to influence and be influenced by other identity characteristics (i.e., gender, race) (D’Andrea & Daniels, 2001), and it affects the overall quality of people’s lives (e.g., how long they live, their health, their success in school, etc.) (D’Andrea & Daniels).

Despite these factors, SES has not been well-recognized as a cultural construct. Some authors have suggested that SES it is not recognized because it blends in and interacts with other client characteristics (Liu, Ali, et al., 2004). Other writers have said that SES should not be understood in isolation from race, gender, and ethnicity, but, rather all of these client diversity characteristics should be understood in terms of how they intersect with one another (Constantine, 2002; D’Andrea & Daniels, 2001; Liu, Ali, et al.; Robinson, 1993). Therefore, SES merits further attention in how its cultural values and underpinnings may impact a counselor’s reaction to a client of a different SES. The following section describes the types of values considered to be associated with SES, and
how different levels of SES have been characterized in a mental health context. This section also reviews the findings from previous research related to SES and counselor bias, and identifies needs for further research in this area.

Socioeconomic Status and Counselor Bias

This section will examine the values associated with the concept of SES, it will also review the research findings associated with SES and counselor bias, and it will briefly discuss SES in relation to counselor cognitive and emotional responses.

Socioeconomic Status Values

The quality of the therapeutic relationship may be impacted by perceptions of SES that counselors bring into treatment. For example, it has been argued that most Western counselors represent a white, middle class background in their therapy approach (Lott 2002; Sue & Sue, 2003). The values associated with this type of background closely relate to the Protestant Work Ethic (PWE) (Bullock, 1995) which is centered on individual responsibility for one’s own success (Cokley et al., 2007). This emphasis can potentially be problematic for clients whose value systems do not emphasize individual responsibility (Sue & Sue, 2003). In fact, Lott (2002) suggested that SES value differences such as these have resulted in negative counselor bias against lower SES clients.
**Socioeconomic Status and Counselor Bias Research Findings**

The scanty research that exists has found evidence of counselor bias related to client SES, but the results are dated (i.e. 1970s and early 1980s) and have been equivocal. For example, reports of earlier research found negative counselor bias against clients of lower SES in the form of less favorable mental disorder diagnoses (Abramowitz & Dokecki, 1977). However, a review of later research (1970s-1980s) found inconsistency in the overall findings of SES and clinical judgment bias (Garb, 1997). Garb attributed inconsistency among these studies to factors such as differences in sample sizes and differences in the operational definitions of SES among each of these SES bias studies.

If SES is an important client diversity characteristic, why is there such a paucity of research in the field? There have been several suggestions for the lack of empirical attention. Some authors have suggested that during the height of SES research in the mental health field, findings were becoming redundant pointing to negative clinician bias towards clients of lower SES backgrounds (Abramowitz & Dokecki, 1977). These findings were explained as due to differences in clients’ levels of insight related to their SES background (Abramowitz & Dokecki). It has also been suggested that the introduction of the women’s rights movement during the 1970s and 1980s shifted the focus from SES bias research to gender bias research (Abramowitz & Dokecki).

**Socioeconomic Status and Counselors’ Cognitive and Emotional Responses**

Diagnosis and treatment recommendations have been the primary focus for counselor bias in most SES studies (Garb, 1997; Lopez, 1989). This form of methodology is not uncommon for clinical bias research, which has typically examined counselor
reactions according to ratings of client diagnosis, symptom severity, prognosis, recommended treatment approaches, length of therapy, and therapy outcome (Lopez). Although these types of measurements represent the more obvious behavioral outcomes of SES bias, they may not capture the indirect ways in which counselors perceive their clients’ needs and problems.

It has been suggested that future research should extend this focus to include counselor ratings of client motives, attitudes, defense mechanisms, and causal explanations for client behaviors (Garb, 1997). These types of constructs represent counselor cognitive reactions to client. In addition, another area of counselor bias which requires further exploration is the counselor’s emotional reactions to the client. These represent the types of emotions which are stirred within a counselor when working with certain client populations.

Counselor cognitive and emotional reactions to a client are two forms of counselor reactions not commonly recognized in SES research. They represent the more subjective qualities of counselor judgments that can be extremely influential to the clinical judgment process. For the purposes of the present study, a counselor’s cognitive reactions represent the type of attributional judgments a counselor makes about a client. A counselor’s emotional reactions are viewed as the counselor’s objective countertransference toward a client. Both of these types of reactions can provide insight into how counselors think about and feel about clients with differing characteristics. Therefore, the present study was designed to broaden the scope of SES research by examining both counselor attributional judgments and counselor objective
countertransference reactions related to clients of different SES backgrounds. The next two sections will further explain these two concepts.

Counselor Attributional Biases Related to Socioeconomic Status

Counselor attributional judgments are the causal explanations or attributions counselors make about the etiology of a client’s problems (Chen, Froehle, & Morran, 1997; Rabinowitz, Zevon, & Karuza, 1988; Strohmer, Biggs, Keller, & Thibodeau, 1984; Weiner, 1979). Counselors not only interpret the cause of client problems, they may also assign responsibility and solutions for the problems (Rabinowitz et al.). They may make either internal or external attributions about the source of these problems. Internal attributions view a client’s personality as being responsible for his or her problems (Sue & Sue, 2003). External attributions consider environmental influences as responsible for client problems and behaviors (Sue & Sue). These attributions are influenced by the types of values, opinions, and beliefs that counselors may hold. Thus, the relationship between counselor attributions and client SES are of particular interest to the present study. For example, counselors who hold values which emphasize personal responsibility, motivation and success (i.e., protestant work ethic), may conceptualize the origins of their clients problems and behaviors differently than counselors who hold different values.

Socioeconomic Status and Attributional Bias Research Findings

Research on attributional bias in the mental health field is very limited. Most studies related to SES have been conducted within the educational setting and have focused on the causal attributions of children’s behaviors (Baron, Albright, & Malloy,
1995; Calhoun, 1975; Darley & Gross, 1983; Stevens, 1980, 1981). There appears to be few adult studies in mental health research examining client SES and counselor attributional bias. Therefore, the present study broadened the knowledge base for attributional research by focusing on what types of attributional judgments counselors make about adult clients from different SES backgrounds.

Counselor Objective Countertransference Reactions Related to Socioeconomic Status

The second type of counselor reaction examined in the present study was a counselor’s objective countertransference (emotional) reaction. In the present study, objective countertransference referred to the evoked and/or elicited emotional reactions in a counselor to specific characteristics or behaviors of a client (Schwartz, Smith, & Chopko, 2007). More specifically, the present study was interested in whether counselors had similar reactions to clients from differing SES backgrounds. For the purposes of the present study, objective countertransference should be differentiated from the psychoanalytic conceptions of countertransference, in that objective countertransference focuses on a therapist’s emotions induced by a client’s interpersonal style, characteristics or behavior, rather than stemming from a counselor’s own unresolved personal conflicts as understood by the traditional psychoanalytic definition of countertransference (Schwartz et al.). However, reference to the word ‘countertransference’ will be used throughout the text when referring to the basic concepts of countertransference to which both objective countertransference and subjective countertransference apply. It is also important to note that many researchers do not make the distinction between the two forms of countertransference (i.e., objective and subjective) in their studies. Therefore,
any references to countertransference research will use the original terminology that was used by the researcher, even if the research relates to the concepts of objective countertransference.

Although early classical views of countertransference perceived it as harmful to the therapy process, contemporary thought is that understanding countertransference reactions can aid counselors in better understanding and helping their clients (Schwartz et al., 2007). In addition there does not seem to be debate as to whether counselors show countertransference feelings related to their clients. It is more a matter of whether these countertransference feelings can be helpful or harmful to the process of therapy (Kiesler, 2001). Countertransference can influence a counselor’s level of anxiety, how they conceptualize their clients, and how they behave towards clients (i.e., avoidance, withdrawal, over-involvement, or under-involvement) (Hayes & Gelso, 2001). Relative to client SES, Javier and Herron (2002) suggested that counselors can experience strong reactions to clients from lower SES backgrounds. They suggested that these feelings can range from feeling sorry for clients or blaming clients for not taking personal responsibility for their problems.

**Client Diversity and Objective Countertransference Research Findings**

There has been little empirical research examining the influence of client diversity characteristics on counselor countertransference. Most research in this area has focused on the effect of client diagnoses on counselor countertransference reactions (e.g., McIntyre & Schwartz, 1998). Even fewer studies have examined other client diversity characteristics, such as client personality (Holmqvist & Armelius, 1996) and client sexual
orientation (Hayes & Gelso, 1993; Milton, Coyle, & Legg, 2005). Only one empirical study was found which considered client SES (Waldron, Turner, Barton, Alexander, & Cline, 1997). Because many of these studies have found evidence of strong countertransference reactions when working with clients of diverse backgrounds, the present study’s goal was to advance understanding the impact of SES on counselor countertransference reactions. The present study examined whether counselors hold positive or negative objective countertransference reactions toward clients from differing SES backgrounds.

Advancement of the Profession

To understand how SES impacts counselors’ thoughts and feelings it must first be recognized as a viable part of clients’ cultural identity. In recent years, some authors have been critical that multicultural competence initiatives (such as the “Multicultural Counseling Competencies”) (Arrendondo et al., 1996) have focused more on client ethnicity rather than including other aspects of client diversity (such as SES) (Fuertes, Bartolomeo, & Nichols, 2001; Weinrach & Thomas, 2002). The importance of considering SES as client diversity characteristic in counselor education is highlighted by a recent study conducted in the field. This study found a relationship between the attitudes of counselor educators and the behaviors they exhibited regarding race, gender, sexual orientation, and SES (Miller, Miller, & Stull, 2007). For example, these researchers found that faculty reported more biased attitudes toward persons of differing SES backgrounds than differing genders or races. The results from this study highlight the need for creating awareness of SES as part of the counselor education process.
If more was understood about how SES influences counselor cognitive and emotional reactions toward clients the field could be advanced in several different ways. In terms of counselor education, awareness of SES differences could be increased, SES bias could potentially be decreased, and multicultural competence for counselor-trainees could be improved. In terms of counselor supervision, supervisors could be better assisted in helping their supervisees become more self-aware of their own SES worldviews and their cognitive and emotional reactions toward clients from varying SES backgrounds. In terms of counseling research, the study of counselor cognitive bias, objective countertransference, and SES could be promoted to include counselor attitudes, thoughts, and feelings related to clients of different SES backgrounds. Ultimately, increased knowledge of SES as a diversity characteristic could help improve the effectiveness of those serving all clients regardless of SES background.

Purpose of Study

The purpose of the present study was to empirically investigate how counselors respond cognitively and emotionally to clients of different SES backgrounds. The research design utilized here extended the scope of earlier studies by examining the cognitive and emotional reactions of counselors through operationalizing attributional bias and objective countertransference reactions. The present study utilized an analogue research design, which is meant to resemble or approximate the therapeutic condition (Heppner, Kivlighan, Wampold, 1999). The present study controlled client SES through the use of both written case summaries of simulated clients accompanied by client video simulations. Participant responses were measured by the Clinical Attributional Scale
(Chen, Froehle, & Morran, 1997) and the Impact Message Inventory-Circumplex (Kiesler & Schmidt, 2006). These are two quantitative and validated instruments designed to measure cognitive and emotional client-related reactions.

**Research Questions**

1. Do counselors demonstrate different cognitive reactions (attributional biases) toward clients from a lower versus higher SES background?
2. Do counselors demonstrate different emotional reactions (objective countertransference reactions) toward clients from a lower versus higher SES background?

**Chapter Summary**

There has been a dearth of research related to SES and clinician bias. The research that has been found is dated (i.e., 1970s to early 1980s) and has yielded inconsistent results (Garb, 1997). Most of these studies have focused mainly on diagnosis and treatment recommendations as a measure of SES clinician bias (Garb). Although these measurements are useful, they do not capture how counselors conceptualize their clients’ cases and explain their behaviors, or how they feel about their clients during a therapy session. Therefore, it was the intent of the present study to counselors’ cognitive and emotional reactions to clients of different SES backgrounds.

In the present study, counselor cognitive and emotional reactions were viewed as attributional biases and objective countertransference reactions, respectively. A literature review revealed that the amount of prior research related to SES and either attributional
bias or countertransference is scanty. The scarcity of research in these areas highlights a broader inattention to how SES impacts people’s subjective experiences of economic status, and the importance of SES on how counselors view their clients (Liu et al., 2004). The present study sought to understand the cognitive and emotional aspects of counselors’ reactions to clients of differing SES backgrounds.

Definition of Terms

The following is a list of terms and their definitions frequently used in the discussion of the current study.

1. Attribution- making a judgment about the quality of a person’s character and abilities.

2. Attributional Bias- Explanations made about the cause of an individual’s behavior and controllability of their problems which are inaccurate and represent distortions of reality (Olson, Jackson, & Nelson, 1997).

3. Objective Countertransference- Evoked and/or elicited emotional reactions in a counselor to specific aspects, characteristics or behaviors of client (Schwartz et al., 2007). For clarification, objective countertransference is different from subjective countertransference. Subjective countertransference represents the traditional psychoanalytic conception of countertransference, where the focus is on a counselor’s own unresolved personal conflicts (Schwartz et al., 2007). For the purposes of the present study, objective countertransference was examined instead of subjective countertransference, because the focus was on evoked/elicited emotional reactions of the counselor in relation to client SES.
background, rather than being based on a counselor’s personal or subjective history. However, in most cases, throughout the literature and research reviews for the present study, countertransference will be discussed in general conceptual terms, unless the type of countertransference (i.e., objective or subjective) needs to be differentiated.

4. Socioeconomic Status (SES) - an individual’s current combined financial (i.e., annual income), educational (i.e., years of formal education), and occupational (i.e., type and rank of paid employment) status relative to one’s broader social community.

5. Worldview- comprised of our attitudes, values, and opinions and which affect how we think, act, define events, and make decisions (Sue & Sue, 2003).
CHAPTER II
REVIEW OF THE RELATED LITERATURE

Introduction

In this chapter there are three major areas reviewed, including literature related to socioeconomic status (SES), attributional bias, and objective countertransference. The background of each area is important to understand separately because of their unique research and theoretical backgrounds. Understanding them within the context of the interaction they have with one another is also pertinent. Mental health literature related to SES will be discussed first, as it serves as the main foundation upon which attribution and objective countertransference rest within the framework of the present study. A review of literature related to attributional bias and objective countertransference reactions will follow. These latter two sections will broadly explain relevant theoretical concepts, and their relation with SES.

Overview of Socioeconomic Status

This section will provide an overview of SES in relation to: SES as a cultural construct, bias related to SES, research related to SES in the mental health field, a critique of SES and clinical bias research, and the need for examining counselor cognitive and emotional responses in SES clinical bias research.
Socioeconomic Status as a Cultural Construct

In reviewing the mental health literature related to client characteristics, SES is often cited along with gender and race, but it does not seem to be given the importance one would expect as a key aspect of client diversity. Zandy (1996) noted, “Often it is named as a part of a cluster of multicultural concerns, but then it seems to disappear, eclipsed by other identities” (p.7). Likewise, Smith (2005) asked

After recurrent calls for attention to counselors' awareness and attitudes regarding the poor-and after multicultural competence has become a mainstay of practitioner training with regard to other aspects of difference- why has there been virtually no advancement in their preparation to work with poor clients? (p. 691)

Similarly, Frable (1997) stated that “with few exceptions, class as a meaningful identity is simply absent from the psychological literature” (p. 154). Ultimately, SES as a client characteristic may be viewed by counselors incompletely, and the depth of its cultural components is not usually fully considered.

One study (Liu, Ali, et al., 2004) examined the frequency and use of SES in the empirical and theoretical literature among three main mental health-related journals from 1981 to 2000: *Journal of Counseling Psychology, Journal of Multicultural Counseling and Development*, and the *Journal of Counseling and Development*. The authors found that only 18% included the construct as the main intent of the article (54% of these articles were empirically based and 46% conceptually based). Only 13% of the empirical articles which included SES used it as a variable throughout the entire article. Liu, Ali, et al. also found that SES was usually mentioned in a nominal way and was used more as a demographic variable than as a research variable of interest.
According to Liu and Pope-Davis (2003), a problem with viewing SES as a descriptor or demographic variable is the use of the “stratification approach.” They stated that the process of stratification is measuring a person’s income, education, and occupational type and level, and then placing someone into a nominal social class. They suggested that stratification approach is limited in being able to explain relationships which arise within SES, or exploring the reasons why people behave or think they way they do. Despite these limitations, information obtained from the stratification method is often used to infer a person’s way of thinking (Liu, 2001). The problem is that researchers tend to assume homogeneity, meaning that they believe “…once people are placed in a class or are allowed to choose what class they believe they belong to, then people will consistently behave and think from that class" (Liu, p. 144). Hence, conclusions are drawn about a large grouping of people and then are suggested to be representative of a specific individual’s own worldview, which may not be the case. Therefore, it is important to understand within-group differences and how people in a certain social class themselves define the characteristics of the class they are in (Liu).

What seems to be missing from current research approaches is the consideration of SES as a true cultural construct, and understanding clients’ own SES perspectives (Liu et al., 2004). Storck (1997) calls for a need to consider SES dynamics, cultural theory and psychological theory in our view of SES. In fact, Storck reframes SES and refers to it as ‘psychosocial class.’ This construct is a person's level of education and type of occupation, combined with behaviors, thoughts and feelings that include expectations and value systems with which a person manages everyday life and his or her relationships with others, in local groups or larger communities and societies. (Storck, p. 334)
Similarly, Liu et al. suggested that SES comprises the intersection of a person’s own intrapsychic world and the economic context in which he or she lives. Ultimately, the economic context that people find themselves in affects their overall culture and therefore how others view them interpersonally.

*The Culture of Poverty Theory*

The ‘culture of poverty’ concept became notable during the 1960’s, stemming from the ethnographic work of Oscar Lewis (1963/1998) and his study of Mexican culture. It emphasized individual traits or characteristics which are associated with people living in poverty. Lewis (1966/2002) described people in the culture of poverty as having “a strong feeling of marginality, of helplessness, of dependence, and of inferiority” (p. 274). He suggested that poverty is not solely the result of economic deprivation, but that there are certain behavior styles that are passed on and “perpetuated through time, regardless of changes in the circumstances of the people” (Goode & Eames, 1996, p. 407).

Some believe that traits ascribed to the ‘underclass’ are a reflection of the cultural ideology of industrial capitalism, which “justifies the existing social order with its significant inequality in resources” (Goode & Eames, 1996, p.407). In turn, it is felt that the philosophies which are associated with the culture of poverty theory can create obstacles which impede the therapeutic process (Javier et al., 1995). While the focus of the culture of poverty examines individual character traits, some opposing beliefs take a more macro perspective in viewing poverty.
Structural Constraints Theory

A more macro-level view of poverty portrays lower SES persons as victims of structural and economic constraints (Mutaner, Eaton, & Diala, 2000). Goode and Eames (1996) argue that “poor people’s ways of life . . . are realistic adaptations to bad situations, rather than due to personal failings” (p. 405). Research conducted on welfare mothers illustrates this notion. In a qualitative study, welfare mothers’ reflections on personal responsibility (Scarborough, 2001) were examined. They felt that they acted responsibly, considering the economic decisions facing them. However, in situations where childcare cost up to 32% of a mother’s income, mothers would choose welfare over a job because the other alternative would have led to poor quality childcare and homelessness (Scarborough). This study supports the macro view for explaining poverty in which society is to blame for creating economic constraints on individuals. Ultimately, it is important that counselors understand the different worldviews of clients from differing SES backgrounds. It is also important that counselors gain self-awareness regarding their own values in order to more fully understand how their personal history specifically, and Western counseling theories generally, influence perspectives of clients and intervention decisions.

Value Orientations and Worldviews

According to the classic writings of Kluckhohn and Strodtbeck (1961), value orientations are complex but definitely patterned (rank-ordered) principles, resulting from the transactional interplay of three analytically distinguishable elements of the evaluative process-the cognitive, the affective, and the directive elements-which
give order and direction to the ever-flowing stream of human acts and thoughts as these relate to the solution of “common human” problems. (p.4)

Value orientations result from the process of combining what we think about life, what our inclination is toward a particular course of action, and what we feel is desirable (Carter, 1991).

Worldviews relate to how an individual “sees the world from a moral, social, ethical, and philosophical perspective” (Lonner & Ibrahim, 1996, p. 295). According to Sue and Sue (2003) “not only are worldviews composed of our attitudes, values and opinions, and concepts, but also they may affect how we think, define events, make decisions, and behave” (p.268). Sue and Sue suggested that our worldviews are guided by how we perceive control and responsibility in our lives. We can either perceive responsibility for our situation in life as being the result of our own inadequacies, or stemming from external circumstances (Sue & Sue). Sue and Sue suggested that differences in these perspectives between a counselor and client can have a significant impact on the therapeutic process.

Worldviews and Counseling

There are certain value systems related to SES which have been identified with counseling. For example, the ideas associated with most Western therapeutic approaches in mental health have been characterized as being predominantly “White” and “middle-class” (Sue & Sue, 2003, pp. 278). Lott (2002) stated that “the glaring omission of social class in considerations of multicultural issues illustrates certain realities about the discipline of psychology. Psychological theories are preoccupied with people . . . in the
middle class (and primarily European Americans)” (p.101). This statement reflects the notion that SES is often overlooked as a cultural construct because certain middle class values have been found to provide the foundation for most therapeutic approaches.

The values which best describe the White and middle-class cultural philosophy in America emphasize internal locus of control (IC) and internal locus of responsibility (IR) (Sue & Sue, 2003). In the IC-IR worldview, it is believed that individuals can shape their fate through their own actions (IC) and that individuals attribute their current life situation to their own efforts and abilities (IR) (Sue & Sue). Although this philosophy may work well for clients who are “White” and considered to be “middle-class”, it may not work well for other individuals. Some authors have suggested that traditional middle-class counseling approaches have become less appropriate for people from a lower SES (Javier et al., 1995).

The individual focus described above has often been associated with the Protestant Work Ethic (PWE) ideology (Bullock, 1995). The PWE ideology was first introduced by Max Weber in 1905 (Cokley et al., 2007). It describes a value system that “stresses the moral value of work, self-discipline, and individual responsibility in forming a way to improve one’s economic well-being.” (Cokley et al., p. 76). The philosophy that one’s success is dependent on one’s own ability and hard work can significantly impact how counselors make attributions about their clients (Liu, 2001). If left unexplored, counselor judgments and decision-making styles can take the form of negative stereotypes and SES-related bias.
Bias Related to Socioeconomic Status

Although it is recognized that stereotypes, prejudice, and discrimination can occur at any level of SES (Liu, Ali, et al., 2004; Liu, Soleck, et al., 2004), for the purposes of the present study, the literature review will focus on bias toward individuals from a lower SES. The most notable derogatory names used to describe individuals from a lower class standing in popular media include: trailer-park trash, hillbilly, red-neck, and white-trash (Liu & Pope-Davis, 2003). Stereotypes which have been used to describe lower SES behavior include: uneducated, unmotivated, lazy, unpleasant, angry, stupid, dirty, immoral, criminal, alcoholic, abusive, violent, unreliable, and impulsive (Lott, 2002; Javier et al., 1995).

Liu, Pickett, Jr., and Ivey (2007) warn against an ‘upward mobility bias’ in counselors towards clients of lower SES backgrounds. This type of bias assumes that individuals are interested in upward social mobility, achievement, and success. If clients do not subscribe to these characteristics, counselors may label them as lazy, deviant, or unmotivated (Liu et al., 2007). On the other hand, some counselors could develop a more patronizing or paternalistic attitude toward lower SES clients, viewing them as being victims and without personal agency (Liu et al.).

Negative counselor attitudes have been found to influence their desire to work with clients from a lower SES background. Wyche (1996) stated that "any counselor familiar with case conferences has heard counselors assume that lower-class people are not good candidates for therapeutic efforts while YAVIS (young, attractive, verbal, intelligent, and successful) people are" (p. 36). Lower SES clients have difficulty finding quality care because doctors or mental health counselors do not desire to work with low-
income clients when given the opportunity (Lott, 2002). As Leeder (1996) stated, “the extent to which a counselor wants to work with a client is influenced by the client's class status. The literature is clear that many counselors have negative attitudes toward and little desire to work with the poor” (p. 53).

It is believed that when counselors do choose to work with individuals from a lower SES, insight-oriented therapies are usually considered less appropriate than problem-solving therapies (Franklin, 1986; Smith, 2005). The assumption is that individuals in this group are not capable of benefiting from insight-oriented strategies. Based on these assumptions, bias and discrimination can influence counselors’ assessments, which include focusing more on client inadequacies instead of client resources and personal strengths (Harley, Jolivette, McCormick, & Tice, 2002). One form of bias related to counselor judgments has been called stereotypic explanatory bias (Sekaquaptewa et al., 2003). This bias occurs when counselors have certain expectations about their clients’ behaviors based on certain stereotypical assumptions that they have about them (Sekaquaptewa et al.). If clients do not act in a way that is expected of them, counselors may explain away behaviors which do not fit in with the expected stereotypes. Counselors may then filter out anything that does not confirm their stereotypes, which can greatly impact judgments of clients and the treatment process (Sekaquaptewa et al.).

Socioeconomic Status Research in Mental Health

This section will discuss past SES related research in the mental health field. It will begin with a description of the classic New Haven Study and then include a brief review of research related to SES and clinical bias.
The New Haven Study

The “New Haven Study” (Hollingshead & Redlich, 1958), which investigated the relationship between social stratification and mental illness in Connecticut in the 1950’s, is considered to be responsible for the surge of SES research during the 1960s and 1970s. In their study, Hollingshead and Redlich sought to determine whether mental illness is related to SES and how a “mentally ill” patient’s social class affects treatment received. In this study, social class was derived at by determining the individual’s residential address, the occupation of the head of household, and years of schooling achieved by head of household. Social class was broken down into five categories: Class I and II being the highest social class standings, Class III being the middle standing, and Class IV and V being the lowest class standings. Based on these class standings, Hollingshead and Redlich (1958) found that persons from a higher class (i.e., I and II) were more likely to be diagnosed with a neurotic disorder than individuals from a lower class (i.e., IV and V), who more likely to be diagnosed with a psychotic disorder. They also found differences in the treatment recommendations based on clients’ social class. That is, psychiatrists had more negative attitudes toward lower class persons. The authors stated that

the need and value of insight therapy is not appreciated by lower class patients. Class IV and V persons seek material help in the form of pills, needles, obscure rays, and ritual; some actually seek support and sympathy. This is certainly not the kind of cooperation the psychiatrist needs who attempts to administer psychotherapy. (Hollingshead & Redlich, p.346)

In this statement, the opinion that insight therapy is not suited for individuals from a lower class is apparent. Ultimately, the findings reported from The New Haven Study became a seminal paper examining the relationship between SES and mental illness. However, the themes which emerged seemed to set a tone for future research by inferring
causation linking an individual’s SES background to a diagnosed mental disorder (Eaton & Mutaner, 1999). Since this seminar work, other research studies have investigated additional aspects of SES and clinical bias.

*Introduction to Research Findings for Socioeconomic Status and Clinical Bias*

The following review is meant to serve as a representative sample of research studies examining the relation between SES and clinician bias in the mental health field. These particular studies were selected in order to represent the general findings and the types of research paradigms which have previously been reported (Abramowitz & Dokecki, 1977; Garb, 1997; Lopez, 1989). In general, it is important to note that most of these studies use the phrase “social class” to describe what is most defined in the present study as SES. The terminology used by the original researchers will be used in each review. An overall critique will follow after all of the research studies have been reviewed because of the similarities among them.

*Evidence of Clinical Bias*

In a study by Trachtman (1971), the researcher sought to determine whether bias was affected by the psychosocial features of the therapist (i.e., characteristics of high or low authoritarianism and level of status anxiety) when interpreting Rorschach scores of clients. Clients’ social histories were modified to indicate lower class status or middle class status. Participants ($N=120$) consisted of male psychologists ($n=60$), Veteran’s Administration staff ($n=15$), Veteran’s Administration clinical psychology interns ($n=9$), private hospital or mental health staff ($n=18$), and county or city hospital staff working in
psychiatric units (n=18). Participants reviewed a written social history of a fictitious client with a description of client residence, occupational history, and their family members’ statement about the client. Then, participants were asked to complete a 42-item scale designed to measure Authoritarianism and Status Anxiety, as well as a 13-item Rorschach evaluation which included diagnostic and prognostic judgments about the client. Significant findings (p<.01) showed that judgments favored middle class clients, and that greater pathology and less favorable prognoses were typically assigned to lower class clients.

In one study using written case descriptions of a client followed by audio-taped interview simulations, DiNardo (1975) investigated the influence of clinicians’ prior diagnosis of a client on a participant’s own assessment of a case (designated a middle or lower social class client) and whether social class impacted these assessments. The study involved a 2X3 factorial design, and the participants were graduate students in clinical psychology (N=60). Their diagnostic impression was measured by a 60-item Q-sort designed by the researchers and a 9-point prognosis on a psychotherapy scale. However, validation of these two instruments was not reported. Greater pathology ratings (p<.05) were assigned to lower class clients than middle class clients. Moreover, the prior diagnostic suggestion of the psychiatrist significantly increased the participants’ ratings of pathology.

In a similar study, Lee and Temerlin (1970) examined the impact of a client’s reported SES on a clinician’s diagnostic and prognostic ratings. Participants were psychiatric residents (N=40) from three different medical schools. The researcher read a case history of a fictitious client to the participants, which reported the client’s
occupation, education, amount of monthly income, and type of residence in order to reflect high, middle, or low SES. Participants then listened to an audio-taped interview simulation. They were asked to rate the client’s level of mental health on a 9-point scale ranging from normal to neurotic to psychotic. They also rated the client’s prognosis on a 9-point scale. Validation of the scales was not reported. It should be noted that the participants were not made aware of the purposes of the study and believed that the client was real when the study was conducted, which raises ethical considerations about informed consent. Significant correlational results showed that the lower class client was more likely to be diagnosed as mentally ill and rated as having fair prognosis, while the middle class and upper class clients had no significant differences on either variable.

In a study conducted by Routh and King (1972), the researchers examined social class bias according to clinician ratings of client descriptions. They utilized 24 stimulus paragraphs, each one containing a description of a simulated client’s age, gender, occupation (designating a lower or middle class impression), behavioral characteristics, and mood state. The participants (N =47) included 15 clinical psychologists and 32 students enrolled in a psychology introductory course. The participants were asked to respond with a single rating for each paragraph read, which asked on what level the person described was in need of professional help for an emotional problem (7-point rating ranging from 1-extremely unlikely to 7-extremely likely). An ANOVA showed a significant main effect wherein the clinical psychologist participants rated the stimulus client higher in the likelihood of needing professional help than the student participants. There was also a significant main effect wherein middle class stimulus clients were rated as being more likely to be in need of help than lower class stimulus clients.
Little or No Evidence of Clinical Bias

Some studies related to clinician bias and client SES found either no evidence of bias in clinical judgments or had mixed results in their findings. In a study by Bamgbose, Edwards, and Johnson (1980), researchers examined the effects of race and social class on clinical judgments of 61 clinical psychologists (21 black males, 40 white males). Instead of using simulated client cases, the researchers utilized real clients. The ethical procedures and general processes in which those clinical cases were obtained was not discussed. Each participant received a written case description of a client which identified the client’s presenting problems, race and social class status. Then participants were asked to assign a diagnosis, rate the severity of the client’s pathology on a 7-point scale of indicating severity of psychopathology, and judge the client’s disposition represented by a 7-point scale. The details and validity of these single response scales were not discussed. The researchers stated that three consensual reviews were used to validate agreement on the client’s actual diagnosis. Correlational analyses revealed that race and social class did not appear to influence participants’ diagnoses of their clients.

Umbenhauer and DeWitte (1978) examined the effect of a patient’s race and social class on clinicians’ diagnosis, prognosis, and treatment. This was a survey study which sought the responses of three different groups of professionals with differing levels of experience. There were a total of 527 respondents, which included 251 psychiatrists and psychiatry residents, 150 psychologists and psychology graduate students, 95 social workers, and 31 ‘other’ professionals. Each participant received a simulated female client case containing the client’s history and presenting problem, as well as a description of race (black or white) and social class (upper or lower class). The level of social class was
designated by educational level, place of residence, and type of employment. Participants were asked to make clinical judgments by ranking the client according to degree of disturbance, motivation for change, impulse control, and ability to form a relationship with the therapist. They were also asked to rank their top three choices for recommended treatment options from a list of fifteen possible treatments. The validity of the rating scales was not reported. Results of a MANOVA revealed that significantly more favorable clinical judgments and treatment recommendations were made for upper class clients than for lower class clients. Upper class clients were also seen as having significantly better ability to form a relationship with the therapist. However, the differences between the lower and higher class clients were not significantly different from one another in regard to the other remaining clinical judgments: degree of disturbance, motivation for change, and impulse control.

Settin and Bramel (1981) examined therapist perceptions related to client social class and gender. They used a survey research method with 418 respondents, which consisted mostly of clinical psychologists (81% male, 19% female). Each participant received a written client case history, which designated gender and lower or middle social class (using Hollingshead and Redlich’s [1958] social class classification based on occupation and educational characteristics). The participants responded to 10 statements using a 6-point Likert-type scale designed to tap attitudes of the participants. No validity for the rating system was reported. The statements tried to capture the therapist’s response related to: usefulness of the intervention, prognosis, interest in providing intervention, comfort on initial contact, client likeability, client competency, client warmth, client’s level of activity, client strength, and client understandability. Results of
a MANOVA revealed that there were no main effects related to social class in general. However, there was a social class by gender interaction main effect, which demonstrated that the higher the social class of a male client the more favorable a therapist’s attitude, while the lower the social class of a female client the more favorable a therapist’s attitude.

Critique of Socioeconomic Status and Clinical Bias Research

Limited research has examined the effect of client SES on clinician bias in the field of mental health. Studies which have been reported were primarily conducted in the 1970s through the 1980s. Not only is this research dated, but there exist several issues of concern related to the research methodology used. These particular issues are outlined below.

Near Extinction of Socioeconomic Status and Clinical Judgment Bias in Mental Health Research

Abramowitz and Dokecki (1977) reviewed literature from the 1960’s and 1970’s related to the impact of social class, race, sex, and values on clinical judgment. They counted fourteen analogue studies, which examined the potential for social class bias in clinician judgment. Overall, they concluded that most of the studies found the existence of negative evaluative bias against clients from a lower social class. However, since the 1960’s and 1970’s the literature on social class bias significantly declined. This is largely attributed to the consistent nature of findings supporting favoritism toward middle and upper class clients, support for the notion that lower class clients are a product of their
environment, and increasing attention toward sex bias related to the introduction of the women’s rights movement (Abramowitz and Dokecki). By the 1980’s Smith (2005) described a shift away from research on SES and mental health due to a new focus on biology, neurology, and genetics of mental disorders. The considerable decline in studies of SES over the previous 20 years highlights the need for additional research using updated and validated instruments while employing clinicians from contemporary society (many of which may have received more focused training underscoring client diversity characteristics as compared with clinicians from the 1960s and 1970s).

Research Design and Methodology

The most utilized research design reported for studies in this area is the analogue research method. In these types of studies, researchers attempted to simulate the counseling experience by using fabricated case studies and client actors. Many of these studies asked participants to rate a simulated client based on written case histories or descriptive paragraphs (e.g., Routh & King, 1972; Settin & Bramel, 1981; Trachtman, 1971; Umbehauer & De Witte, 1978). In some studies, such as Di Nardo’s (1975) and Lee and Temerlin’s (1970), researchers not only used written case summaries but also had participants listen to an audio-taped client interview simulation. Video simulations have not typically been used in mental health research, probably because the equipment was either not available or too costly for researchers to use during that period of time. However, video simulations have been used in similar research in other fields of study, such as the Darley and Gross (1983) study, in which evidence of clinical judgment bias was found after the participants viewed a video simulation of a written client case. The
details of this particular study will be reviewed later under studies related to attributional bias. Studies such as this one, point out the need for more utilization of video simulations in future research in this area.

Sample Size

In general, many of the studies related to clinician bias and client SES contain very small sample sizes. In the studies referenced above, the average sample size ranged from 40-60 participants, with the exception of the two survey studies (418 participants and 527 participants, respectively). In his review, Garb (1997) commented that studies which reported less evidence of clinician bias were studies which seemed to have larger sample sizes (i.e., 266 average sample size), versus studies which used smaller participant samples (i.e., 49 average size). Considering the noticeable relationship between small samples and larger samples relative to significant findings of clinician bias, sample size (and adequate statistical power) should be an important consideration for future studies.

Participants

In most of the studies cited above, participants have been limited to clinical psychologists, psychology graduate students, and psychiatrists and psychiatric residents, with only a few reporting other mental health professionals (such as social workers). The population samples also appear to be male-dominated in cases where gender of the participants is reported. There have been many changes in mental health care and the introduction of new types of mental health professionals since the time period in which these studies were conducted. The introduction of more women and racially diverse
clinicians to the field of mental health, as well as the founding of the profession of counseling, is an important consideration for the development of new research in the area. Including a more diverse sample population, and in particular professional counselors, may help advance knowledge in this area.

Validity of Instruments

The validation of instruments used in most of the studies cited above was not reported. Many of the studies relied on a survey-style questionnaire or a series of questions/statements which required a Likert-style scale response. Most often these scales were self-created by the researcher(s) (e.g., Bamgbose & Edwards, 1980; Di Nardo, 1975; Lee & Temerlin, 1970; Routh & King, 1972; Settin & Bramel, 1981; Trachtman, 1971). This form of measurement calls into question the validity and reliability of each study’s findings, and may explain the overall inconsistencies in the research findings related to SES bias research in mental health field. It is therefore important that future research use instruments with adequate psychometric qualities.

Types of Clinical Judgments

In SES-related studies participants have traditionally been asked to make clinical judgments about simulated client cases. The most frequently reported ratings of clients has been in the form of diagnosis, prognosis, level of pathology, and recommended treatment options for the client (e.g., Bamgbose & Edwards, 1980; Di Nardo, 1975; Lee & Temerlin, 1970; Routh & King, 1972; Trachtman, 1971; Umbenhauer & De Witte, 1978). Based on his review, Garb (1997) suggested that studies related to clinical bias
and SES rarely asked clinicians to make ratings of the client’s motives, attitudes, and defense mechanisms. Neither did they ask the clinician to describe or suggest the cause of the client’s behavior or problems. It has also been noted during this literature review that clinician emotional reactions had not been investigated empirically. This observation highlights a new area of SES clinical research which has been thus far unexamined.

**Summary of Research Critique for Socioeconomic Status and Clinician Bias**

In consideration of client SES as a valid diversity characteristic, the present study was designed to modernize and improve upon research related to clinical judgment bias and client SES in the field of mental health. In regard to research design, the present study added video simulation to the client case review, designed to capture clinician bias related to visual appearance of the client. The present study also employed a larger sample in order to increase the power and enhance the generalizability of results. In relation to participant selection, the present study included professional counselors as participants who were not previously recognized in most studies related to this topic. Regarding instrumentation, the present study utilized two previously validated instruments, the Clinical Attribution Scale (Chen et al., 1997) and the Impact Message Inventory-Circumplex (Kiesler & Schmidt, 2006), in contrast to the common use of non-validated instruments employed in previous research. Lastly, the present study sought to examine clinical judgment bias beyond diagnosis, prognosis, and treatment recommendations by incorporating two forms of clinical judgments (counselor attributional bias and objective countertransference reaction) not previously investigated.
in SES clinical research. The following section makes a differentiation between cognitive and affective responses, as they are understood within the present study.

Cognitive and Affective Responses to Socioeconomic Status

In the present study, attribution was considered to be a counselor’s cognitive reaction to a client, whereas objective countertransference is seen as an affective (or emotional) reaction to a client. In order to understand attribution and objective countertransference in these contexts, it is important to differentiate between what is meant by a cognitive response and what is meant by an affective response. An attribution is understood as a causal judgment or explanation a counselor makes about an observed behavior (Fiske, 1993; Weiner, 1979). Objective countertransference is understood as various intrapersonal (i.e., affective) reactions in the counselor manifested as a result of contact with a client’s unique characteristics, personality, or style (Schwartz, 2001; Schwartz et al., 2007).

Zajonc (2000) viewed affect and cognition as two distinct and separate processes. In this view, a cognitive response is “evidence of recognition of a given stimulus as familiar and thus confirming its retrieval from memory,” and an affective response is an “individual’s expressed or inferred preference for one stimulus over another or others” (Zajonc, 2000, p. 32). Conscious and nonconscious cognition is specific, dedicated, addressed, and referenced, whereas nonconscious affect can be gross, diffuse, undedicated and unaddressed (Zajonc, 2000). This means that cognitive responses rely on information we have already stored in our minds about a particular issue, however affective responses do not necessarily rely on previous experience or logic. Rather,
individuals can make inferences simply based on what feelings are evoked. For the purposes of the present study, a counselor’s cognitive response was defined by a counselor’s attributions, which are his/her judgments and explanations for a client’s behavior. A counselor’s affective response was defined in terms of his/her objective countertransference reaction to the client, which is comprised of the counselor’s emotional reaction (positive and negative feelings) toward a client.

Review of Literature Related to Attributional Bias

This section will review the literature related to attributional bias. It will include an overview of the theories related to attributional bias, the relation between attributional bias and SES, and a research critique of past attributional bias and SES research.

Overview of Theory Related to Attributional Bias

This overview will include: how attribution is defined in the literature, an examination of attributions of causality, the mechanisms of attributional bias, and the relation between attributions and stereotypes.

Attribution Defined

In its simplest form, the term attribution refers to when an individual assigns or ascribes a particular characteristic or quality to a person or thing (Webster, 1988). In the therapeutic context, attribution has often been associated with counselor judgments, and is commonly used to describe a counselor’s evaluation and assessment of a client’s character and abilities. The central function of the attributional process is to identify the
causal factors which have produced a certain type of behavior (Brewin & Antaki, 1987). Once these factors are identified or labeled, counselors make implicit and explicit decisions within their decision-making process which determine whether or not to accept a client, identify appropriate treatment interventions, and determine the success of therapy (Rabinowitz et al., 1988). They also make causal inferences about the etiology of their clients’ mental health problems (Chen et al., 1997; Rabinowitz et al.; Strohmer et al., 1984). More specifically, counselors make judgments which relate to the client’s responsibility for the problem, and the client’s responsibility for the solution to the problem (Rabinowitz et al.).

Attributions of Causality

In his theory of attribution of causality, Weiner (1979) proposed three dimensions for causality of a problem, including locus of causality, stability, and controllability of a problem. In this theory, locus of causality referred to Rotter’s (1966) theory of locus of control, which assigns causes as being either internal, within a person, or external, outside a person. Weiner’s (1979) illustration of locus of causality relates to how one perceives “health.” For example, is a person’s health perceived to be internal (“I am a sickly person”) or external (“The flu bug got me”)? Locus of stability rates a person’s causes on a continuum of being stable (unchanging) or being unstable (changing). Some examples of stable causes are a person’s ability, his or her typical effort, and his or her family situation. Some unstable causes include a person’s immediate effort, his/her attention and his/her mood during a situation (Weiner).
Weiner’s (1979) third dimension of controllability is different than locus of control in that it relates to a person’s intentionality. This dimension examines a person’s intentions related to the cause of his or her problems. For example, the involvement of a person’s mood in the cause of his/her problems is seen as unintentional, or uncontrollable, he or she was not deliberately trying to create change. However, a person’s effort denotes something intentional; he or she was trying to enact a change, which is seen as controllable (Weiner).

All three of Weiner’s (1979) dimensions were seen as the cognitive processes which guide counselors to begin to formulate inferences about the causal roots of their clients’ problems. However, Rabinowitz et al. (1988) have suggested that traditional attributional analyses focus primarily on how causality is assigned to past or current events in the client’s life, yet overlook the cause and control of the client’s future behavior. These theorists strongly feel that consideration of the client’s cause and control of future behavior is very closely linked to the act of goal setting for clients and has the power to dictate the direction of therapy and the treatment process. They stated,

the question of who should be responsible for solving the presenting complaint is an often overlooked but central one in psychotherapy. Only by making judgments about the client's future potentials, and the extent to which clients can be seen as responsible agents in seeking solutions to their problems, can the counselor rationally design and implement interventions. (Rabinowitz et al., p. 182)

This theory posits that how counselors perceive who is to blame for causing the client’s problem, and who is responsible for solving the problem, greatly impacts how they approach helping their clients.

In the theory related to attribution of responsibility for a problem and solution to the problem, there are four primary models of the helping and coping process (Brickman
et al., 1982; Karuza, Zevon, Gleason, Karuza, & Nash, 1990; Karuza, Zevon, Rabinowitz, & Brickman, 1982). In the moral model, individuals were seen as being responsible for both the cause and solution of their problem. In the compensatory model, individuals were seen as not responsible for the cause of their problems, but responsible for solving them. In the enlightenment model, individuals were seen as responsible for the cause of their problems, but not responsible for the solution to their problems. Lastly, in the medical model, individuals were not seen as responsible for the cause of their problems, nor the solution to their problems.

The effectiveness of therapy can greatly depend on which helping and coping model a counselor and client each subscribe to. If helping professionals view clients as responsible for their problems and solutions to their problems, they may not give help that may be needed. Alternatively, if professionals do not hold that clients are responsible for problems nor the solutions to their problems, they may provide help to clients who may be capable of helping themselves (Brickman et al., 1982). In consideration of these potential dilemmas, counselors are encouraged to maintain flexibility throughout the course of therapy and modify the helping and coping approach and match it according to the client’s needs. Rabinowitz et al. (1988) stated,

for each psychotherapeutic school, the attributional assumptions not only define the nature of the presenting complaint, but offer the counselor a criterion, or definition of a fully functioning, adjusted client. The thrust of the therapeutic endeavor is to lead the client to this goal. In this traditional sense, the process of therapy is theoretically canalized. (p. 197)
**Mechanisms for Attributional Bias**

The literature related to attribution has often been paired with the concept of bias. The occurrence of attributional bias has been described as biased mechanisms for explaining others’ behavior which may not be accurate, and may instead represent stereotypes or distortions of reality (Olson et al., 1997). Attributional bias has also been explained as being either an underestimation of situational influences related to the cause of behavior, or an overestimation of dispositional influences (i.e., traits) related to a person and the cause of his/her behavior (Miller & Porter, 1988). One of the most common attributional biases is fundamental attributional error (Jones & Harris, 1967; Ross, Greene, & House, 1977) which is one individual’s attribution of another person’s behavior to dispositional factors rather than situational factors. Attributional biases have the potential to impact the therapeutic relationship and clinical judgment process, yet it is unclear from what type of processes these biases stem.

Related to the areas of social perception and social cognition, Fiske (1993) stated that accuracy in perception is not absolute and that it depends on one’s purpose. In general, she stated that “people try to make sense of each other in order to guide their own actions and interactions” (Fiske, p. 156). Fiske also suggested that when people begin to describe others, they describe them using trait adjectives which are presumably thought to help them to predict others’ behavior. These trait adjectives often take the form of stereotypes.
Stereotypes

Stereotypes are considered to be “a socially shared set of beliefs about traits that are characteristic of members of a social category” (Greenwald & Banaji, 1995). They guide people’s actions toward others, who are considered to have the traits associated with the stereotype (Greenwald & Banaji). In some schools of thought, stereotypes help people make sense of their social world, and they are used because they have explanatory value, given information, motivation, and social norms (Fiske, 1993). However, the accuracy of stereotypes are often called into question, especially considering the standards upon which the stereotypic judgments are based (Fiske).

The concept of stereotypic explanatory bias has been subject of recent research related to information processing. This type of bias is more likely to occur when individuals make explanations for behaviors that are inconsistent with their expectations, than when they receive information which is consistent with their expectations (Sekaquaptewa et al., 2003). A review of research findings concluded that behaviors which are considered to be stereotype inconsistent are more likely to be attributed to external causes, whereas, behaviors which are considered to be stereotype-consistent are more likely to be attributed to more internal stable causes (Jackson, Sullivan, & Hodge, 1993).

Relative to mental health, causal attributions made by counselors about their clients’ behaviors can lead to stereotyping. In turn, stereotypes can have negative evaluative implications and behavioral consequences (Fiske, 1993). If the stereotypes are inaccurate it could lead to improper treatment plans or cause counselors to socialize clients into accepting potentially dysfunctional views of themselves and their problems.
(Karuza et al., 1982). Of particular concern, is the assertion that causal explanations can be influenced by social group membership of the individual (Sekaquaptewa & Espinoza, 2004). This point is particularly important considering the nature of the present study, and the focus on client diversity related to client SES and variances in counselor attributional reactions and objective countertransference reactions.

Attributional Bias and Socioeconomic Status

Batson et al. (1982) suggested that although earlier studies found evidence of more dispositional explanations for client behavior by trained counselors, this did not necessarily mean that there was concrete evidence of bias or attributional error. They described methodological problems with the traditional approaches used by the bulk of attributional studies conducted in the 1960s and 1970s. They proposed that these studies used ambiguous definitions for identifying “normal” clients in their studies. They also found that these studies had the tendency to narrow a participant’s response type by providing them with predetermined standards in their client case reviews. In addition, some of these studies compared a client’s own attributions for his or her problems with the counselor’s attributions, even though the client’s attributions could also be inaccurate. Overall, Batson et al. suggested that the focus of attributional research should shift away from the characteristics of the personnel (i.e., trained versus untrained counselors, or theoretical orientation of the counselor) and, rather, focus on what is beneath the attributions. They stated that this would help us to better understand what types of situational factors can produce bias and under what conditions. In fact, some research related to attribution and SES seems to have followed in this direction.
Attributional studies which have examined the influence of SES have occurred mostly in the school setting. In one earlier study, Calhoun (1975) examined how SES influenced perceived causes of hyperactivity of children. The participants consisted of 80 teachers and teachers-in-training enrolled in graduate classes in education. They were provided with a brief biographical paragraph about a hyperactive child of unspecified sex. Information about the child’s race, SES and characteristics of the child’s hyperactivity were varied across the cases. SES was identified in the descriptive paragraph by direct statements such as the following, “This pupil comes from a white, middle socioeconomic class family” (Calhoun, 1975, p.196). The participants’ responses were recorded through the use of rating scales, reflecting causal factors, developed by the researcher. The validation of these scales was not reported. With each question or statement on the scales, participants were asked to rate the child’s level of hyperactivity according to certain causal factors, and then recommend whether the child should be referred to a school psychologist or to a teacher for learning disabled children. The results of a three-way ANOVA revealed that the child’s race and SES did not appear to have an influence on perceived causes for hyperactivity. However, the overt manner in which the child’s SES information was reported may lead to problems associated with social desirability of the results of the respondents. Another concern related to this study relates to the lack of information related to how the scales were developed and any information regarding the scales’ validity.

The methodology of the Calhoun (1975) study was later improved upon by the work of Stevens (1980, 1981). Stevens’ study examined the relationship of ethnic identification and SES to the attribution of positive and negative characteristics and
hyperkinetic behavior of a child observed in a school setting. Participants included 27 teachers, 24 school psychologists, and 24 parents. Participants read a biography of a fictitious child, watched a videotape of the child’s behavior in a classroom, and were asked to rate the child “according to other children they have ever known” (Stevens, 1980, p.1285). SES was designated in each biography by a description of the parents’ occupations and the location of the family dwelling. The instrument was a 9-point Likert-type rating scale containing 20 characteristics identified as positive, negative, or hyperkinetic characteristics. The scale underwent a factor analysis (Hoyt reliability was .87) which revealed three primary factors associated with positive, negative, or hyperkinetic characteristics. The significant findings of an ANOVA and MANOVA found that teachers rated significantly less negative behaviors to perceived middle SES children than to the perceived lower SES children. In addition, school psychologists were found to attribute more hyperkinetic behavior to the lower class children and ethnic minority children.

Similar attributional studies also examined how SES impacted judgments made about children’s academic abilities. For example, Darley and Gross (1983) examined hypothesis confirming biases related to expectancy confirmation. In this study, they provided participants with a case review of a child, had them view a video simulation of a child, and then had them make judgments of the child’s ability level. Half of the participants viewed a video which depicted the child in an urban, low-income area, while the other half were shown a video which depicted the same child in a middle-class, suburban setting. The participants were 30 male and 40 female undergraduates who had no reported formal teacher training. Some participants were asked to rate the child’s
ability level after they read only the written case of the child (designated as higher or lower SES). Other participants rated the child’s ability after they read the (higher or lower SES) written case and viewed a videotape simulation of the child. Participants completed several rating scales which asked them to rate the child’s academic and performance abilities, as well as, rate the child according to certain characteristics related to 20 traits or skills. The results showed that the children who were perceived as having a higher SES were attributed a higher ability level, and lower SES children received a lower ability rating. How the child’s level of SES was designated in the written case was not provided in the details of this study. In addition, the appropriateness of the rating scales used in this study with participants who had no known assessment experience is unclear.

Baron, Albright, and Malloy (1995) sought to improve upon the Darley and Gross (1983) study, whereby they manipulated the information of the child to convey either clear or ambiguous information about the child’s academic ability. Participants included 81 female and male students from an introductory psychology course. All participants were asked to view either the higher or lower SES videotape (used from the Darley and Gross study), and then three fourths of the participants were asked to view one of three performance tapes, which showed the child performing at one of three different ability levels in answering test questions correctly. Rating scales utilizing a 7-point Likert-style response. The validity of these scales was not reported. The results of an ANOVA revealed that SES did not influence the judgments of the child’s ability level when the academic ability information about the child was clear and unambiguous; however, SES
was found to impact the rater’s judgments when participants (control group) did not view the child’s performance tape.

In a study by Charles and Littig (1982), the researchers examined the types of attributions (internal or external) observers make about another person when their SES backgrounds are similar. Participants were 80 male undergraduates who read a written vignette describing a person’s background and SES information (designated by education, occupation, and income). Participants were also identified as belonging to either a “blue-collar” or “white-collar” background, based on the participants’ parental SES information. Then the participants were asked to write an explanation of how the actor ‘…got to be who and what he is today.’ The responses were then coded according to internal or external attributions. There was 70% agreement between the two coders examining the same participant responses. The results of this study showed that participants, regardless of their own SES backgrounds, tended to give internal explanations when actor’s SES outcomes were different from actors’ SES backgrounds. In addition, participants gave external explanations when actors’ SES backgrounds and outcomes were similar. The methods in which the researchers employed to measure participant response have questionable validity. In addition, the manner in which participants were categorized as higher or lower SES is questionable considering they were all college undergraduates.

In a Canadian study combining social class and ethnic differences, Mann and Taylor (1974) found that 100 university students representing the majority ethnic group (English Canadian) were influenced by the actor’s SES level, attributing more negative characteristics to lower SES actors. However, participants (64 university students)
representing the minority ethnic group (French Canadian) were more influenced by actor ethnicity, giving more positive attribution towards actors of their own ethnic group (French Canadian). Participants had recorded their responses on a set of three questionnaires, which described the behaviors being performed by an individual described as being from one of two ethnic groups, and one of two possible social classes (low and middle). The specific details of the questionnaire and the validation of this measure were not recorded.

Attributional Bias and Socioeconomic Status Research Critique Summary

There is a paucity of research related to attributional bias in the mental health field, particularly as it relates to SES. Earlier studies in related to SES and attribution have found limited evidence of dispositional bias related to expectancy confirmation and stereotypical explanations for the behaviors of others. However, the mixed results and conclusions of many of these studies indicate that there is still much empirical exploration needed. General weaknesses, associated with studies related to SES and attributional research, are outlined below.

Participant Samples

Many of the studies which have examined SES and attributional bias have stemmed from the field of social psychology. The participants used in these studies were often drawn from a general undergraduate or graduate student population (e.g., Baron, Albright, & Malloy, 1995; Charles & Littig, 1982; Darley & Gross, 1983; Mann & Taylor). A few of these studies took place in the school setting and used teachers and
school psychologists reviewing the behaviors of children (e.g., Calhoun, 1975; Stevens, 1980, 1981). Although a few studies stemmed from the field of mental health (Pearce, 1994; Redmond & Slaney, 2002), these focused on attributional bias and diversity characteristics such as race, rather than SES. In addition, the populations used in most of these studies relied on undergraduate and graduate students.

**Instruments**

In general, the studies related to attributional bias and SES seem to lack a consistent form of measurement for attributional bias, particularly one that is a well-validated form of measurement. In many of these studies, attribution has been assessed by asking participants to rate the observed individual’s skills and abilities, such as according to academic standards (Darley & Gross, 1983; Stevens, 1980, 1981), and also have participants rate an individual according to a list of character traits associated with internal and external attributions (Baron et al, 1995; Darley & Gross, 1983; Mann & Taylor, 1974; Stevens, 1980, 1981). These character trait lists seem to vary from study to study and their validities have generally not been reported.

**Socioeconomic Status and Attributional Bias and Clinical Judgments in Mental Health**

There is very little research in the mental health field which has specifically examined clinician attributional bias in relationship to client diversity. This review found only two reported studies (Pearce, 1994; Redmond & Slaney, 2002) in the mental health field which examined the relationship of client race/ethnicity to counselor attributional bias. Even Redmond and Slaney concluded that more research is needed in this area, and
highlighted a need for future research to examine SES as an influence on attributional bias.

Section Summary of Attributional Bias

How a counselor attributes the cause and solution to a client’s problems can greatly impact the process of counseling. Research has found that these attributions are vulnerable to the process of stereotyping (Jackson et al., 1993; Johnston, Bristow, & Love, 2000) and can result in biased interpretations of client behaviors. In particular, a review of attributional research related to SES found that an individual’s SES background has been shown to impact how others attribute their problems. In general, research in this area is sparse and most of prior studies lack the use of valid and reliable instruments. Attributional bias research specific to the field of mental health has focused primarily on client race, and no attention found to date has focused on client SES.

Overall, the present study sought to add to attributional bias research, specifically related to the mental health field, by examining the role of client SES in its relationship to the occurrence of counselor attributional bias. It also sought to make improvements to preexisting studies in this area by using professionals in the field of counseling rather than graduate and undergraduate students. The present study also used a validated attributional measure, the CAS (Chen et al., 1997). With an understanding of attributional bias and SES counselors can better empathize with and more objectively treat clients. In addition, attributions may unconsciously affect counselors’ emotional reactions to clients. The following section will summarize literature related to objective countertransference, and specifically how it may be influences by client SES.
Review of Literature Related to Objective Countertransference

This section will review the literature related to objective countertransference. It will include a definition of objective countertransference, an overview of objective countertransference theory, and a review of objective countertransference research related to client diversity.

Overview of Objective Countertransference

In the present study, objective countertransference is viewed as counselor emotional reactions to clients. Just as causal attributions can have an impact on counselor judgments, counselor affect can also significantly impact counselors’ decision-making and therefore the counseling process. Affective states of individuals hold the power to influence judgments made by people (Forgas & East, 2003). They may not only influence what people think but how people think (Forgas & East). In the same way, counselor countertransference has been regarded as having a significant impact on the course of therapy. According to Corey (2005), it is said that unless counselors’ are aware of their own needs as well as their own dynamics, it is very likely that their own dynamics will interfere with the progress of therapy.

Countertransference in the traditional Freudian psychoanalytic sense has been described as being the “counselor’s version of transference; accordingly, the patient comes to represent an object of the counselor’s past onto whom feelings and wishes derived from unresolved conflicts are projected” (Strupp & Binder, 1984, p. 146). In conjunction with the occurrence of client transference, from this perspective counselor countertransference stirs up unconscious feelings within counselors. Gelso & Hayes
(1998) suggested that countertransference is a counselor’s reaction to a client and it stems from a counselor’s own unresolved intrapsychic conflicts. Corey (2005) stated that countertransference “occurs when there is inappropriate affect, when counselors respond in irrational ways, or when they lose their objectivity in a relationship because their own conflicts are triggered” (p.68). Countertransference can be observed through counselors’ cognitive, affective, and behavioral reactions to their clients (Hayes, 1995).

The construct of countertransference and its technical significance to the therapeutic process has been widely debated. The more “classical” view of countertransference held that it is detrimental to therapy (Gelso & Hayes, 1998) and that competent counselors are typically “immune” from its effects (Strupp & Binder, 1984). Additionally, the classical view suggested that if counselors do find themselves reacting to their clients’ transference, they should seek to “expunge” those feelings immediately, either through self-analysis or consultation because they lead to “undesirable interference” in the therapeutic process (Strupp & Binder, 1984, p. 147).

A more contemporary view of countertransference holds that it is an opportunity to understand more about clients by addressing the emotions which are evoked during a therapeutic session (Strupp & Binder, 1984). Sharing this philosophy, Kiesler (2001) stated that "by rejecting transferences and parataxic distortions as valid features of psychotherapy, one finds oneself in the unfortunate position of not attending to or detecting aspects of client's "live" behavior with the counselor that might express his/her basic interpersonal issues” (p. 1054). Kiesler sees utilizing countertransference reactions as an opportunity to advance the therapeutic process.
There are two general forms of countertransference discussed in the literature, objective countertransference and subjective countertransference. In his review, Kiesler (2001) suggested that objective countertransference is a counselor’s emotional reaction to certain client behaviors to which other observers would also have similar reactions, whereas, subjective countertransference stems from a counselor’s own unresolved conflicts and anxieties (Kiesler). In this theoretical framework, subjective countertransference represents the traditional psychoanalytic conception of countertransference, where the focus is on a counselor’s own unresolved personal conflicts (Schwartz et al., 2007). This form of countertransference (subjective countertransference) is not the focus of the present study.

The present study focused on objective countertransference, where a counselor’s emotional reaction is evoked or elicited by specific characteristics or interpersonal behaviors of the client (Schwartz et al., 2007). This means certain aspects about the client can trigger common emotional responses in a counselor. Some client diversity characteristics which have been empirically examined in relation to objective countertransference include: diagnosis, sexual orientation, and certain age groups (Schwartz & Wendling, 2003). For the purposes of the present study, objective countertransference was examined instead of subjective countertransference, because the focus was on evoked/elicited emotional reactions of the counselor in relation to client SES background, rather than being based on a counselor’s personal or subjective history.

It is important to note that throughout the present study’s literature and research reviews, references will be made to the term “countertransference” when discussing the general theoretical concepts related to countertransference or when researchers do not
make the differentiation between objective and subjective countertransference in their own studies. Specific references to objective countertransference will be used when it is necessary to differentiate objective countertransference from subjective countertransference.

Overview of Objective Countertransference Theory

Although the definition and relevance of countertransference has been debated, Kiesler (2001) has identified several elements of countertransference upon which most theorists seem to agree. According to Kiesler, the one consensus was that the counselor is no longer considered to be neutral and anonymous. Another point of consensus suggested that it is unavoidable for clients to use the counselor as a “transference object.” One other consensus was that countertransference is transactional, that is it involves both the client and the counselor in mutual interactions. Another consensus was that client behaviors can trigger counselor experiences. It was also suggested that it is not a question of whether or not a counselor shows emotions to his or her clients, but rather, whether the emotions evoked in counselors are helpful or harmful to the therapeutic process. Lastly, Kiesler asserted that because countertransference can play a prominent role in therapy, the success of therapy depends on how well a counselor is able to manage his or her own countertransference reactions.

Gelso and Hayes (1998) have identified their own set of propositions related to countertransference. First, they stated that countertransference can be utilized in such a way that it benefits therapy. However, if it is left unmanaged it can have a negative impact on therapeutic process. They recommended that counselors should possess certain
abilities in order to better manage their countertransference reactions. These abilities include: self-integration, anxiety management, conceptualizing skills, empathy, and self-insight. There are five main categories identified as characteristics associated with countertransference: origins, triggers, manifestations, management of countertransference, and therapy outcome (Hayes & Gelso, 2001).

*Origins*

The origins of countertransference may be related to common emotional reactions toward clients’ interpersonal styles and attributes (Kiesler, 2001).

*Triggers*

Countertransference triggers may include client attributes, such as how a client appears and presents himself or herself to the counselor whether physically, interpersonally or intrapsychically (e.g., symptoms of a particular mental disorder).

*Manifestations*

Countertransference can manifest itself affectively, cognitively, and behaviorally. For example, affective manifestations may take the form of anxiety or fear when a counselor perceives a client as personally threatening. Cognitive manifestations may be manifested as a distorted view of clients’ issues. Behavioral manifestations might include avoidance of, withdrawal from, under-involvement with, or even over-involvement with clients during sessions. In the present study the affective manifestation of countertransference will be investigated.
Client Diversity

According to Schwartz and Wendling (2003) research on countertransference reactions toward specific client populations is scanty. In their review of research dated 1990-2001, they found only 14 studies on this topic. The major categories of diverse populations identified focused on adults with personality disorders and other mental illnesses, clients coping with past traumas, human sexuality, and children and adolescents. It should be noted that only one study to date mentioned SES as a research variable. This is surprising considering the current professional emphasis on multicultural aspects of counseling and the fact that countertransference was identified as a construct during the early 1900s (Schwartz & Wendling). Based on these limited findings, Schwartz and Wendling have called attention to a significant need for more research in this area.

Socioeconomic Status and Client Diversity

One area of client diversity which has not been adequately researched, as it relates to countertransference reactions, is client SES. A literature review showed that thus far the relationship between client SES and counselor countertransference reactions has only been reported once in the literature.

In their writings, Javier and Herron (2002) explored theoretical countertransference issues related to working with clients living in poverty. They contended that lower SES clients have not been well understood by traditional psychoanalytic approaches.
The point is that the poor person brings a particular set of characteristics to a therapeutic situation that are distinct from the patterns of the usual patient who has provided the clinical material for most of the existing psychoanalytic theory and technique. Thus, for most analysts who find themselves working with a patient who is economically deprived, there is a sense of confusion. At some point, the analysts find themselves perplexed by the unfamiliarity of the life of the patient and feel themselves struggling with how to make the process helpful. (Javier & Herron, p. 152)

Javier and Herron suggested that working with lower SES persons can bring about a “powerful set of feelings” which can represent a “fear of the poor” (p. 162). These attitudes can lead to countertransference reactions such as feeling sorry for the client, blaming society and deemphasizing personal responsibility. These attitudes can also have an opposite effect such as blaming the patient, emphasizing personal responsibility, and excusing society (Javier & Herron).

SES can generate many countertransference reactions which have implications on the therapeutic process. For example, Gojman de Millan (1997) stated "... the individual backgrounds and the socially determined experiences of the patients and the analysts are interwoven in the therapeutic encounter” (p. 248). In this regard, Javier and Herron (2002) suggested that countertransference reactions can be integrated into the therapy process in productive ways, such as simply discussing these social class differences with the client or by shifting cultural identities. The key to accomplishing this important and realistic goal is to more fully understand countertransference through additional empirical research (Schwartz et al., 2007). The following section describes representative examples of research related to countertransference and client diversity characteristics.
Review of Objective Countertransference Research and Client Diversity

There has been some research conducted, although very little, related to diversity characteristics and counselor objective countertransference reactions. Many of these studies have examined the relationship of patient diagnoses on counselor reactions. Fewer have examined client characteristics other than clinical diagnoses (McIntyre & Schwartz, 1998). For example, several studies have examined counselor reactions toward gay and lesbian clients. Milton et al. (2005) conducted a qualitative study in order to understand the perspectives of psychotherapists who described themselves as working in lesbian and gay affirmative therapy, as well as lesbian and gay clients who have received affirmative therapy. They interviewed 14 psychotherapists and 18 lesbian and gay clients. Grounded theory was used to analyze the interview information. The themes emerging from these interviews showed that countertransference can influence the process of psychotherapy. It was found that a therapist’s sexuality can emotionally impact a therapist working with lesbian and gay clients. Interviewees generally felt that it would be difficult for a heterosexual therapist to overcome countertransference anxieties about homosexual persons. They suggested that those anxieties could make it difficult for the therapist to empathize with lesbian or gay clients, and may even cause them to take a defensive pathologizing stance toward same sex sexualities.

In the study by Hayes and Gelso (1993), male counselor reactions toward gay and HIV infected clients were examined as they related to level of homophobia and death anxiety. Thirty four counseling psychologists completed a demographic questionnaire, as well as a 31-item scale which contained 15 items related to a death anxiety scale and 16 items from a homophobia scale. Participants then viewed one of eight videotapes of a
Results of a MANOVA found that counselors experienced greater discomfort with HIV-positive clients. Also, counselor’s level of homophobia predicted their discomfort with gay clients more than with heterosexual clients. Although the procedures and instruments in the study appeared to be sound, the sample size was very small which is a concern for external validity.

Gelso, Fassinger, Gomez, and Latts (1995) examined male and female countertransference reactions to lesbian and heterosexual female clients. Participants consisted of 67 masters and doctorate-level clinical psychology and counselor education students, as well as some college student personnel and interns. Participants responded to Daly’s Attitude Scale for homophobia and the Countertransference Factors Inventory. Then, participants were exposed to a video simulation of either a lesbian client or heterosexual female client. After viewing the video they responded to the State-Trait Anxiety Inventory and a scale for cognitive recall. A MANOVA found no significant effects for sexual orientation. However, they found that greater homophobia lead to heightened avoidance behavior. In addition, they found that the female participants had greater problems than male participants recalling the video of the lesbian client.

The only empirical study found which mentioned client SES and counselor countertransference was conducted by Waldron et al. (1997). These authors examined the relationship of counselor defensiveness and marital therapy process and outcome. They also included the characteristics of marital adjustment and couple SES. Participants included 22 therapists and 88 couples. Half the couples were designated as being middle SES and the other half as low SES, according to the Hollingshead (1965) rating method.
Judges rated 10-minute live segments selected for each of the 88 couples observed in the study. These video segments were coded according to the Defensive and Supportive Communication coding system. Results of a Path analysis showed that couple SES was not found to predict counselor defensive behavior or marital therapy outcome. However, in this study SES was treated more as a demographic variable than as a variable of primary interest. In addition, the Hollingshead (1965) social position scale used has been widely criticized and is considered outdated (Oakes & Rossi, 2003). The use of this scale raises concerns related to the actual SES of participants in this study.

Summary and Critique of Objective Countertransference Research

Empirical research related to objective countertransference is scanty, especially as it relates to the area of client diversity. Aspects of client diversity, which have been examined empirically, have focused mainly on client diagnostic groupings, human sexuality, clients coping with past traumas, and children and adolescents (Schwartz & Wendling, 2003). For example, there have been a few studies which examined counselor countertransference reactions toward lesbian and gay clients. The Gelso et al. (1995) study used video simulations which most closely relate to the methodology used in this study. A review of the findings from some of these studies indicated that a client’s sexual preference can influence a counselor’s countertransference reactions. These authors also point out that more research is needed in the area of client diversity and countertransference. In particular, within the area of countertransference and client diversity SES-related research is virtually nonexistent. In the one study which included SES (Waldron et al., 1997), SES was treated more as a descriptor characteristic and
participants were stratified using what is considered an outdated method of assessing the
construct (Oakes & Rossi, 2003).

The goal of the present study was to expand upon objective countertransference
research and client diversity by examining client SES, a characteristic not previously
examined as a primary variable of interest. The present study utilized a similar
methodology to that of Gelso et al. (1995) and the Hayes and Gelso (1993), however the
use of technology was increased (e.g., use of online surveys and digital video
simulations) and the use of an updated and psychometrically sound objective
countertransference instrument was employed.

Chapter Summary

This review has focused on three areas of SES-related mental health research:
client diversity and clinical judgment bias, attributional bias and counselor judgments,
and objective countertransference reactions. Although each of these areas has the
potential to influence the therapeutic process in many ways, there remains a lack of
research attention related to any of these areas in the field of mental health and within the
profession of counseling specifically.

Very few empirical studies in the mental health field have included SES as a
primary construct (Liu et al., 2004). The bulk of research which has been conducted on
the impact of SES and counselor judgments is outdated, having taken place primarily
from the 1960s-1980s. The SES research which has been completed has largely focused
on counselor clinical judgments related to client diagnosis, personality assessment,
treatment planning, and prognosis ratings (Garb, 1997). There has been a lack of attention
to more subtle, yet influential, areas in which counselors make judgments about their clients such as cognitive attributions for client behaviors and symptoms.

Evidence of bias related to SES has been mixed in mental health research. Some authors have suggested that the inconsistent manner in which SES has been defined is to blame for the contradictory findings (Liu et al., 2004). Others have suggested that the traditional analogue methodology and small sample sizes used in prior research contributed to differing results among studies (Garb, 1997). Considering the current strive for multicultural competencies in the mental health field, it is puzzling why SES has not taken a more prominent place in attribution-related mental health research.

There have been calls for new directions of research related to attributional bias and what types of conditions may produce it (Batson et al., 1982). However, research specifically related to client SES and attributional bias in the mental health field is very limited. Most studies in this area have been conducted in the field of education rather than mental health. These studies have largely focused on the behavior of children (e.g., Baron et al., 1995; Calhoun, 1975; Darley & Gross, 1983; Stevens 1980, 1981), and none have examined counselor behaviors with adults. This is surprising considering what we do know about SES-related bias in society in general. How counselors view their clients’ problems can determine the manner in which they approach the helping process (Karuza et al., 1990).

Empirical research related to counselor objective countertransference reactions is extremely limited, especially related to diverse client populations (Schwartz & Wendling, 2003). In the one study to date that evaluated SES, Waldron et al. (1997) treated SES as more of a demographic variable than as a primary variable of interest. Moreover, an
instrument with questionable psychometric properties was used to cluster clients into SES categories. Considering that counselors’ affective reactions can have a major influence on the course of therapy (Forgas & East, 2003), more objective countertransference research is needed. This is especially related to client diversity factors such as client SES.

The focus of the present study was to advance the field of mental health by better understanding how client SES can influence counselor clinical judgments (i.e., cognitive attributions) and affective reactions (i.e., objective countertransference). It is hoped that the results of the present study will help counselor educators to better train students and counselors to more competently treat clients of differing SES backgrounds.

Research Questions

1. Do counselors demonstrate different cognitive reactions (attributional biases) toward clients from a lower versus higher SES background?

2. Do counselors demonstrate different emotional reactions (objective countertransference reactions) toward clients from a lower versus higher SES background?
CHAPTER III

METHODOLOGY

The purpose of the present study was to better understand how counselors respond cognitively and emotionally to clients of different SES backgrounds. It extends the scope of earlier studies by examining the cognitive and emotional reactions of counselors through the investigation of attributional bias and objective countertransference reactions. The present study utilized an analogue research design, which is meant to resemble or approximate the therapeutic condition (Heppner et al., 1999). The present study manipulated client SES through the use of written case summaries of simulated clients accompanied by client video simulations. Participant responses to written and video client characteristics were measured by the Clinical Attributional Scale and the Impact Message Inventory-Circumplex. These are two quantitative and validated instruments which were designed to measure cognitive and emotional client-related reactions.

Participants and Delimitations

Participants in the present study were selected by a survey sample of counseling professionals who were either members of the American Counseling Association (ACA), or members of different state counseling associations located in various states across the United States, or belonged to a student counseling association associated with a CACREP (Council for the Accreditation of Counseling and Related Educational Programs)
accredited Midwestern university. This sample included a cross-section of individuals involved in local, state, and national professional counseling organizations. One thousand names and emails of ACA members were purchased from the ACA membership directory. ACA member names and emails were selected by ACA guided by the following requirements: 500 males and 500 females, individuals who identified themselves as professional counselors, equal representation from each major region (North, South, West and East sectors) of the United States. In addition to the ACA members, many state counseling associations were contacted by phone and/or email. Although several of these organizations agreed to post the survey invitation, only one mid-western counseling association confirmed the posting of the survey invitation. The survey invitation was also posted on a student counseling listserv. Considering this study was conducted as an internet survey, no controls were placed on email invitations, whereby, participants were encouraged to forward the survey link to other professional counselors known to them.

The sample population in the present study was delimited to professional counselors and counselor trainees. Participants were not delimited based on age, sex, race, marital status, SES, level of experience, level of education, or other academic or demographic factors. A total of 141 professional counselors/trainees completed the online survey, with a total of 67 (47.2%) participants in the higher SES group, and 74 (52.1%) participants in the lower SES group. Participants ranged in age from 22 to 74 years (Mean = 46.65 years, Standard Deviation = 12.67 years). There were 57 (40%) male participants and 84 (59%) female participants. Of the total sample, 122 (86%) were self-
identified as Euro-American, 7 (5%) as African American, 7 (5%) as Hispanic American, 2 (1%) as Asian American, and 3 (2%) as belonging to ‘Other’ race.

With the exception of those earning less that $25,000 annually, reported income levels of participants appeared to be evenly distributed among four categories: 25,000-50,000 (22%), 50,000-75,000 (28%), 75,000-100,000 (23%), and 100,000 and above (20%). The vast majority of participants rated themselves as being at a “Middle” socioeconomic status level (41%). The highest percentage of participants (27%) identified themselves as having 1-5 years of professional experience; however, two other categories (6-10 years and 26 or more years of experience) had the next highest percentages of participants. The majority of participants identified themselves as being Licensed Professional Counselors (50%) or Licensed Professional Clinical Counselors (29%), and also having a Master’s-level education (64%). In addition, most participants reported their relationship status as being married or partnered (68%). Other demographic information about the participants is shown in Table 1.
### Table 1

Demographic Information of Participants ($N=141$)

<table>
<thead>
<tr>
<th>Demographic Information</th>
<th>Frequency</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reported Income Level</strong></td>
<td></td>
<td></td>
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<tr>
<td>Under 25K</td>
<td>10</td>
<td>7.1%</td>
</tr>
<tr>
<td>25-50K</td>
<td>31</td>
<td>22.0%</td>
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<tr>
<td>50-75K</td>
<td>39</td>
<td>27.7%</td>
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<tr>
<td>75-100K</td>
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<td>22.7%</td>
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<tr>
<td>Over 100K</td>
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<td>20.6%</td>
</tr>
<tr>
<td><strong>Self-Reported Socioeconomic Status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower</td>
<td>3</td>
<td>2.1%</td>
</tr>
<tr>
<td>Lower Middle</td>
<td>24</td>
<td>17%</td>
</tr>
<tr>
<td>Middle</td>
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<tr>
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</tr>
<tr>
<td>Upper</td>
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<tr>
<td><strong>Years of Professional Experience</strong></td>
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<tr>
<td>1-5 years</td>
<td>38</td>
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<td>6-10 years</td>
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<tr>
<td>11-15 years</td>
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<td>16-20 years</td>
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<tr>
<td><strong>Licensure Type</strong></td>
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<tr>
<td>Lic. Prof. Clinical Co. (LPCC)</td>
<td>41</td>
<td>29.1%</td>
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<tr>
<td>Lic. Prof. Co. (LPC)</td>
<td>71</td>
<td>50.4%</td>
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<tr>
<td>Lic. Social Worker (LSW)</td>
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<tr>
<td>Lic. Marriage and Family Co. (LMF)</td>
<td>3</td>
<td>2.1%</td>
</tr>
<tr>
<td>Lic. Psychologist</td>
<td>4</td>
<td>2.8%</td>
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<tr>
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<tr>
<td><strong>Education</strong></td>
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<tr>
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<tr>
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<tr>
<td>Living with Significant Other</td>
<td>5</td>
<td>3.5%</td>
</tr>
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</table>
Instruments

This section will provide information related to all of the instruments utilized in the current study, which include: informed consent script, measurement of the demographic characteristics, Marlowe-Crowne Social Desirability Scale, Clinical Attribution Scale, and the Impact Message Inventory-Circumplex.

Informed Consent Script

Before data collection began, participants reviewed an informed consent statement (see Appendix A). The purpose of this information was to make participants aware of their choice to participate in the present study, the potential risks to confidentiality involved in participating in on-line research, and their rights as research participants. This statement included the title of this research study, information about the researcher, the purpose of this research study, procedures that would be used, risks, discomforts, and benefits of the present study. It also included information related to the right to refuse to participate or withdraw from the present study. It informed participants that efforts will be taken to maintain their confidentiality and the confidentiality of the data collected from the study. It also included contact information if participants should have any questions, and a statement related to each participant’s voluntary agreement to participate in the present study.

Measurement of Demographic Characteristics

Demographic information about participants was gathered from the completion of a demographic questionnaire developed by the researcher (see Appendix B). The
demographic questionnaire included information related to the following variables: age, sex, self-identified race, household income, self-perceived socioeconomic status/class, relationship status, licensure status, number of years of professional counseling experience, and number of years of counselor education completed.

Marlowe-Crowne Social Desirability Scale

Social desirability bias occurs when respondents want to please the researcher by giving socially acceptable responses when being tested (Ary, Jacobs, Razavieh, 1996). In order to test for social desirability bias among the participants in the present study, the Marlowe-Crowne Social Desirability Scale (SDS) was used (see Appendix G). The SDS measures bias related to an individual’s need for approval (Leite & Beretvas, 2003). The SDS consists of 33-items, 18 keyed true and 15 are keyed False (Crowne & Marlowe, 1960). The internal consistency coefficient for the SDS, using the Kuder-Richardson formula 20, is .88 (Crowne & Marlowe, 1960). Crowne & Marlowe achieved a test-retest correlation of .89 on this measure. In order to establish validity, the scores from the SDS were correlated with the scores on MMPI subscales and Edward’s social desirability scale scores (Crowne & Marlowe; Leite & Beretvas, 2005). Based on the results of these correlations, the authors concluded discriminant validity was supported. Short forms of the SDS have been created and been put into use in research. However, reliability of these short forms are still suspect. Some have found only two of the six short forms of the SDS as providing the best measure of social desirability (Fischer & Fick, 1993). Others have tested the reliability of the short forms with different participant populations (i.e. adolescents, men, and women) and found lower reliability scores among these
populations (Beretvas, Meyers, & Leite, 2002). Based on these mixed results with the short forms, the original 33 item form was used for the present study. The alpha coefficient for the SDS in the present study was .86, indicating good internal reliability for this measure.

Clinical Attribution Scale

The Clinical Attribution Scale (CAS) is an 18-item, five-point Likert-type measure of dispositional bias published by Chen et al. (1997) (see Appendix D). The items on this scale focused on both dispositional and situational attributions. This scale helped to identify whether a person is more inclined to explain the actions of another as being related to more personality/dispositional characteristics or external/situational influences. Participants rated each response using a five-point Likert-type scale ranging from A = Strongly Agree, B = Agree, C = Undecided, D = Disagree, to E = Strongly Disagree (Chen et al.). In the present study lettered scores were translated to point values for statistical purposes: A = 1, B = 2, C = 3, D = 4, and E = 5. Higher scores on the CAS indicated a more internal (dispositional) inclination and lower scores indicated a more external (situational) inclination to explain a person’s problems.

According to Chen et al., this 18-item scale was adapted from a similar 33-item attributional scale used by Storms (1973), Russell (1982), and Batson, Jones, and Cochran (1979). An item analysis was conducted on the revised CAS which revealed a Cronbach alpha reliability coefficient of .87 (Chen et al.). Chen et al. assessed validity by using expert rater judgments to determine where each item fell on the dispositional-situational continuum. In terms of reliability, their assessment revealed an average
intraclass correlation coefficient of .96 and an average interrater agreement of .9. To date, the CAS appears to be the only documented measure of attribution which measures how an individual makes causal explanations for other people’s problems and behaviors, and which includes published validity and reliability information. In the present study, statistical analysis revealed a Cronbach alpha of .81, indicating good internal reliability for the CAS.

Impact Message Inventory-Circumplex

The Impact Message Inventory (IMI)/Impact Message Inventory-Circumplex (see Appendix E) is a self-report transactional inventory (Kiesler & Schmidt, 2006), which was designed to measure how one interprets or characterizes the personal style of another person (Kiesler, 1987). This is a unique instrument, in that, the IMI does not ask respondents to record their perceptions of others, but rather, it asks respondents to describe their own personal reactions to the person under observation (Kiesler & Schmidt, 2006). It captures the emotional reaction to the personal qualities or impression that one person’s behavior leaves another. In the context of psychotherapy, the IMI allows for the assessment of distinctive covert reactions of both the counselor and client (Kiesler & Schmidt, 2006), meaning that it identifies the kinds of feelings that a person (i.e. client) can elicit in another person (i.e. counselor). Given the emotional qualities that the IMI captures, it has been shown to be a useful measure for countertransference reactions in countertransference research, an area of research in need of additional empirical study (Schwartz et al., 2007; Schwartz & Wendling, 2003). The use of this measure can help to understand how a client’s verbal or nonverbal behaviors can impact a
counselor’s emotional response to that client (Kiesler & Schmidt, 2006). This focus on automatic emotional responses makes this measure appropriate for the investigation of countertransference reactions in the present study.

The original IMI was a 90-item (15 subscales) instrument, which has since been reduced to a 56-item instrument measuring eight categories of interpersonal behavior (Kiesler & Schmidt, 2006). These eight categories (eight subscales) are comprised of the following behavior characteristics: Dominant, Hostile-Dominant, Hostile, Hostile-Submissive, Submissive, Friendly-Submissive, Friendly, and Friendly-Dominant. Each of these eight subscales is made of 7 items each.

A briefer 28-item IMI has also been created in order to meet the demands of research, where time and motivation of the participants is limited. This measure is called the 28-item Impact Message Inventory Circumplex (IMI-C), which uses only the four main anchor characteristics of the octant subscales used in the 56-item measure, without using the combined characteristics. The four primary subscales (or characteristics) include: Dominant, Submissive, Friendly, and Hostile (Kiesler & Schmidt, 2006). Each of these subscales contains the same cluster of seven questions related to each interpersonal style as used in the 56 item version. Each item is rated on a 4-point Likert-type scale according a person’s strength of agreement with each statement (1 = Not at all; 2=Somewhat; 3 = Moderately so; 4 = Very much so). Each subscale reflects the emotions produced within an individual (participant) by indicating how he or she has been impacted by another person’s behavior (simulated client). An example for each of these response styles are listed below:
“When I am with this person, he/she makes me feel…”

- Dominant Subscale ‘bossed around’
- Hostile ‘distant from him/her’
- Submissive ‘in charge’
- Friendly ‘appreciated by him/her’ (Kiesler & Schmidt)

Higher scores for questions related to each of the four subscales reflect stronger emotional reactions in that regard. Considering the nature of the present study, and the concern for participant motivation in completing an on-line survey, the 28-item IMI-C was used.

The IMI has been found to be a valid and reliable measure for identifying emotions related to countertransference reactions. Kiesler (1987) reported good internal consistency reliability for the subscales. Extensive analyses of eight studies using the IMI-C found the following internal consistency reliabilities (Cronbach’s alphas) for the four primary subscales: .85 for the Dominant subscale, .86 for the Hostile subscale, .78 for the Submissive subscale, and .89 for the Friendly subscale (Schmidt, Wagner, & Kiesler, 1999a). Kiesler, Schmidt, and Payne (1990) identified the following internal consistency reliabilities for the IMI from undergraduates’ ratings of acquaintances: .86 for the Dominant subscale, .79 for the Hostile subscale, .64 for the Submissive subscale, and .89 for the Friendly subscale. In Schmidt’s (1989) study, female undergraduates’ ratings of videotaped interviews of normal and personality disordered individuals were examined. The internal consistency reliabilities for the IMI in the Schmidt (1989) study were: .82 for the Dominant subscale, .88 for the Hostile subscale, .84 for the Submissive subscale, and .91 for the Friendly subscale. In addition, a more recent review of 14 IMI-C (Brief Version) samples from four separate studies conducted between 2002 and 2005 reported a median Cronbach alpha range of .61 to .87 for the four primary subscales
(Kiesler & Schmidt, 2006). In the present study, the reported internal consistency reliabilities (Cronbach Alpha) for each of the subscales was .72 for the Dominant subscale, .78 for the Hostile subscale, .72 for the Submissive subscale, and .74 for the Friendly subscale. These results indicate adequate internal reliability for the IMI used in the current study.

Subscales of the IMI have been compared with those of the NEO Personality Inventory-Revised (NEOPI), which demonstrated evidence of convergent validity (Schmidt, Wagner, & Kiesler, 1999b). The correlations between the NEOPI factor scores and the IMI found that NEOPI Extraversion and Agreeableness factors showed a high correlation with the underlying similar IMI dimensions. Significant negative correlations were also identified between NEOPI Neuroticism and the two IMI dimensions (Control and Affiliation) that may relate to this construct. As expected, NEOPI factors of Conscientiousness and Openness were positively significantly correlated with the IMI Affiliation dimension. Based on the psychometric properties of the IMI, Schwartz et al. (2007) have suggested that the instrument is currently the most effective measure for assessing counselors’ emotional reactions to their clients.

Research Design

In order to test the null hypotheses, a descriptive research design (also sometimes termed causal-comparative or ex post facto research methods) was used rather than an experimental design. This design is descriptive because relationships among variables or differences in groups (as is the case in the present study) are generally studied after they have been influenced by another variable (Borg & Gall, 1989). Kerlinger (1973)
explained that “ex post facto research is a systematic inquiry in which the scientist does not have direct control of the independent variables because their manifestations have already occurred or because they are inherently not manipulable” (p. 379). A descriptive research design was used to examine group differences in attributional bias and objective countertransference among counselors viewing a higher versus lower SES client. Although causation cannot be inferred with a descriptive research design, Newman and Newman (1994) explained that “one of the most effective ways of using ex post facto research is to help identify a small set of variables from a large set of variables related to the dependent variable for future experimental manipulation” (p. 124). Descriptive (or causal comparative or ex post facto) research designs are useful when a researcher is able to speculate about the causes of a phenomenon based on prior research, theory and observation (Borg & Gall).

More specifically, the design used for the present study was an analogue design which is a research method designed to resemble the therapeutic setting. It represents an experimental simulation of certain aspects of the counseling process which can be controlled or manipulated (Heppner et al., 1999). In the present study, the client’s portrayed SES background was the only variable being controlled. That is, depending on the assigned group, participants viewed either a lower SES client profile or a higher SES client profile. In both cases, the actor was the same with a similar clinical script, but his or her overall appearance was different. The actor’s language and appearance was manipulated to give the appearance of a lower SES or higher SES client.

According to Heppner et al. (1999), there are several advantages to using an analogue design. One of the key advantages is that the experimenter can provide
situational control in the research process by eliminating extraneous variables, controlling for confounding variables, and by manipulating certain levels of the independent variable. It also allows the researcher to reach a high degree of specificity in the operational definition of a variable. Another very important advantage of analogue design is that it avoids the practical and ethical dilemmas related to conducting research with real clients (Heppner et al.).

The primary challenge related to an analogue research design is the generalizability of the research findings. Some writers believe that the artificial nature of the experimental simulation may not be reflective of a real counseling scenario, making it difficult to draw any conclusions from the results of the study (Heppner et al., 1999). Another challenge associated with analogue design is the issue of social desirability bias. This form of bias occurs when participants are likely to give responses which enhance their image rather than providing honest responses (Ary et al., 1996). Some have suggested that analogue designs related to client SES are subject to social desirability bias (Lopez, 1989). In this case, participants were considered to be likely to make more favorable judgments toward clients of lower SES background because they would not want to appear biased towards lower SES clients. However, in his review of research related to client SES, Lopez found no evidence of social desirability bias associated with analogue design methods compared to that of experimental research designs. In order to rule out social desirability as a confounding variable in the present study, use of a social desirability scale was included.
Procedures

Participants were contacted via email and invited to participate in the present study through the method of an online survey. Their email addresses were obtained from either purchased email directories or from listserv distributions from different professional counseling organizations (local, state, and national). Participants were asked to review an informed consent statement before proceeding with the study, and were informed they could withdraw from the study at any time. Data collection materials included: (a) an informed consent statement (see Appendix A), (b) a demographic questionnaire (see Appendix B), (c) written simulated client case vignette (see Appendix C), (d) the Clinical Attribution Scale (see Appendix D), (e) the Impact Message Inventory-Circumplex (see Appendix E), (f) a clinical questionnaire (see Appendix F), and (g) the Marlowe-Crowne Social Desirability Scale (see Appendix G). Informed consent for participation for the present study was inferred by each participant’s acknowledgment (computer button click) to either proceed with or discontinue the study.

Each participant reviewed a written case vignette describing either a higher or lower SES simulated client and his presenting problem prior to viewing the video recording. The written vignette (see Appendix C) provided the participant with a brief description of the client’s background and presenting problem. Although the background and presenting problem of the simulated client was the same for both the higher and lower SES cases, the client’s occupation, education, and income levels were different based on a higher or lower SES profile. The purpose of the written vignette was meant to stimulate the participant’s cognitive perception of the simulated client.
Once the participants reviewed the written vignette they viewed the corresponding higher or lower SES simulated client on a videotape recording. Video segments included a client presenting for a first counseling session. The client explained his presenting issues, life concerns, and related symptoms. Approximately 4 minutes of a video-taped interview was shown to participants. Videotaped segments were used in the present study, along with written client descriptions, as opposed to audiotapes (e.g., McIntyre & Schwartz, 1988) or only written vignettes (e.g., Brody & Farber, 1996) because they could potentially yield richer and more accurate participant data (Schwartz et al., 2007). The video vignettes were pre-screened by selected judges (i.e., researcher, dissertation chair, and member of dissertation committee) at the author’s originating university who judged the reliability of the video simulations in terms of correctly portraying the client according to a lower or higher SES background, through language and appearance (i.e., clothing and accessories).

The videotape of the client simulated a case assessment where the client shared his presenting problems and life concerns with the counselor for the first time. The focus of the video was on the simulated client. The counselor conducting the assessment session was off camera. The role of the counselor was minimal, only serving to prompt the simulated client with assessment-type questions. Client SES was differentiated in the written client summary and video script by education (i.e., high school versus graduate degree), occupation (i.e., auto body service staff member versus district manager), income (i.e., $20,000 versus $150,000) and lifestyle characteristics (i.e., bowling versus golfing). All other content related information such as family structure (i.e., wife and two kids) and presenting problems (i.e., trouble establishing a social network) remained the
same. In the video presentation, the actor was the same, but client SES was differentiated by appearance (i.e., unshaven versus shaven, t-shirt and jeans versus suit and tie) and language style in the video presentation. The actor was given a checklist describing client symptoms and facts about the client’s family, work, and social life to help ensure consistency across the two videos (see Appendix H). The purpose of the videos was to stimulate the participants’ interpersonal reactions to the higher or lower SES client profiles through nonverbal cues.

The on-line survey data collection was set-up by the researcher and approved by the Internal Review Board (IRB) at the researcher’s originating university. The researcher set up the online survey to assign participants equally to either the lower SES or higher SES simulated client cases. Before participants began the survey they reviewed an informed consent statement, informing them of their rights as participants, the potential risks to confidentiality involved in participating in internet survey research, and their right to withdrawal at any time throughout the research process. Then participants were asked to review a brief case summary of the simulated client and then view a short videotape segment of the lower or higher SES simulated client. Then participants were asked to complete a demographic questionnaire, CAS, IMI-C, a clinical questionnaire, and the SDS.

Data from the online survey was secured through a Secure Socket Layer (SSL) protocol which allowed for secure communications across the internet. The SSL protocol encrypts what the participants input and decrypts it at the web server (Survey Monkey, 2009). The data and participant information was coded by the on-line survey program for the purpose of statistical analysis. All data collection was anonymous. No identifying
data were collected. Participants did not receive compensation or direct benefit from participation in the present study.

Statistical Hypotheses

*Null hypothesis 1:* There is no statistically significant group difference in scores on the CAS between counselors reacting to a lower SES client versus a higher SES client.

*Directional hypothesis 1:* On the CAS, counselors reacting to a lower SES client will display higher scores related to dispositional bias, and those reacting to a higher SES client will show higher scores related to situational bias.

*Null hypothesis 2:* There is no statistically significant group difference in scores on the IMI-C between counselors reacting to a lower SES client versus a higher SES client.

Description of Independent and Dependent Variables

In order to test null hypothesis one, the independent variables were the higher and lower SES client videos that the participants viewed. The dependent variables for hypothesis one were represented by counselor attributional reactions to the observed client’s problems. It was measured by the 18 item Clinical Attribution Scale (CAS). The CAS measured attributional bias which determined whether counselors were more likely to attribute the observed client’s problems to dispositional (personality) factors or situational factors (Chen et al., 1997).

There were several potential covariates identified, depending on whether they were found to have significant relations with either of the two dependent variables (i.e., dispositional and situational bias). These potential covariates included: 1) the counselor’s own self-perceived SES; 2) years of experience working as a counseling professional; 3) counselor’s current income level; 4) counselor’s type of licensure; 5) counselor’s level of
education; and, 6) counselor’s degree of social desirability as measured by the Marlowe-Crowne Social Desirability Scale (Crowne & Marlowe, 1960).

In order to test null hypothesis two, the same independent variables (higher SES client and lower SES client videos) and potential covariates (counselor SES, counselor experience, counselor income, counselor licensure, counselor education, and level of social desirability) as in hypothesis one were utilized. The dependent variables in hypothesis two were the scores from the four primary subscales of the Impact Message Inventory-Circumplex (IMI-C). These dependent variables represented the counselors’ countertransference reactions to the observed clients. The IMI-C measures how one interprets the interpersonal styles of others (Schwartz et al., 2007). The four primary subscales of the IMI-C - Dominant, Hostile, Submissive, and Friendly - measure how counselors feel about the observed client related to the characteristics in each of these areas of interpersonal style (Schwartz et al.; Kiesler, 1987).

Data Analyses

Descriptive statistics, including frequency distributions, means, standard deviations, and ranges, were reported for all demographic, independent, and dependent variables. Then, a pre-analysis was conducted to test whether participants’ own SES, counseling experience, income, licensure, education, and level of social desirability were associated with their attributional biases (CAS scores) or countertransference reactions (IMI-C Scores). Pearson Correlations were used to determine if statistically significant relations existed between the following variables:
counselors’ SES self-ratings with CAS scores
- counselors’ SES self-ratings with IMI-C scores
- counselors’ years of professional experience with CAS scores
- counselors’ years of professional experience with IMI-C scores
- counselors’ income level with CAS scores
- counselors’ income level with IMI-C scores
- counselors’ level of licensure with CAS scores
- counselors’ level of licensure with IMI-C scores
- counselors’ education with CAS scores
- counselors’ education with IMI-C scores
- SDS scores with CAS scores
- SDS scores with IMI-C scores

It was anticipated that, if statistically significant relations were found between the demographic variables described above or social desirability (i.e., SDS) scores, and either of the instruments used to investigate attributional bias (i.e, CAS) or objective countertransference (i.e., IMI-C), these variables would be included in the main analyses as covariates. In addition, it was anticipated that, if the CAS and IMI-C scores were significantly associated with one another, both instruments would have been analyzed together (i.e., in one MANOVA) rather than being analyzed separately.

In order to test hypothesis one, a one-way analysis of variance (ANOVA) was utilized to investigate differences in CAS scores (attributional biases) among the participants viewing the higher or lower SES client videos. This form of analysis tested the significance of group differences between the means of the dependent variable (CAS scores) for each level of an independent variable (higher and lower SES client videos), while also analyzing variation between and within each of these groups (Mertler & Vannatta, 2002; Weinfurt, 1995). This method of analysis was considered to be appropriate for the present study because we were examining the differences in
participant responses to viewing the lower or higher SES client videos, and the variation in each set of group responses in regard to their attributional responses.

In order to test hypothesis two, a one-way multivariate analysis of variance (MANOVA) was used to examine differences in the IMI-C subscale scores (objective countertransference reactions) among the participants viewing the higher or lower SES client videos. This form of analysis is similar to an ANOVA, in that it tests the significance of group differences and the variation between and within the groups, however, it also allows for more than one dependent variable (Mertler & Vannatta, 2002). In this case, the IMI-C contains four sets of subscale scores, which represent four different dependent variables related to objective countertransference. Therefore, the MANOVA was used in the present study to examine each of the dependent variables (i.e., IMI-C subscale scores), while, at the same time, controlling for the correlations among these dependent variables, in addition to studying the variation between the independent variables (i.e., higher or lower SES client videos).

Summary of Methodology

The purpose of this research study was to examine group differences in the attributional and objective countertransference reactions of professional counselors according to a client’s SES background. Participants included professional counselors and counselor trainees. Participants read an informed consent statement, informing them of their rights if they choose to participate in the present study. They received a short case description of a client and view a brief videotaped client simulation. After viewing the
video simulation, participants were asked to complete a demographic questionnaire, the CAS, the IMI-C, a clinical questionnaire, and the SDS.

A pre-analysis was conducted using bivariate correlations, in order to determine whether or not cognitive attributions and objective countertransference reactions have significant relations with each other, or whether each alone had an association with counselors’ SES, level of professional counseling experience, income, licensure status, education, or social desirability responses. Based on the preliminary results, null hypotheses one and two were tested using an ANOVA and a MANOVA, respectively. It was expected that participants reacting to a lower SES client would display greater dispositional biases, and those reacting to a higher SES client would show greater situational biases. The actual findings are presented in Chapter Four.
CHAPTER IV

RESULTS

The purpose of the present study was to examine whether there are differences in how counselors respond cognitively and emotionally to clients of different SES backgrounds. Counselor cognitive and emotional reactions were examined through attributional bias and objective countertransference reactions. This chapter presents the statistical findings related to the present study. The first part of this chapter presents the descriptive statistics of the measures used in the present study, and the second part reports the inferential statistical findings as they relate to the study’s hypotheses.

Descriptive Statistics

The instruments used in the present study included: (a) the Clinical Attribution Scale (CAS), a measurement of attributional bias; (b) the four primary subscales (i.e., Dominant, Hostile, Submissive, and Friendly) of the Impact Message Inventory-Circumplex Brief Version (IMI-C), a measurement of objective countertransference reactions; (c) and the Marlowe-Crowne Social Desirability Scale (SDS), a measurement of a person’s degree of social desirability employed to determine if social desirability should be included as a covariate when testing the research hypotheses. For the total sample \( N = 141 \) participants showed average CAS scores of 51.77 \( ( Standard Deviation = 8.22, \ Range = 18 \ to \ 74 ) \). Average IMI-C scores were 9.22 \( ( Standard Deviation = \) \( \)}.
2.54, \(\text{Range} = 7 \text{ to } 20\) for the Dominant subscale, 10.18 (\(\text{Standard Deviation} = 3.19, \text{Range} = 7 \text{ to } 20\)) for the Hostile subscale, 13.44 (\(\text{Standard Deviation} = 3.48, \text{Range} = 7 \text{ to } 28\)) for the Submissive subscale, and 12.40 (\(\text{Standard Deviation} = 3.23, \text{Range} = 7 \text{ to } 24\)) for the Friendly subscale.

Inferential Statistical Findings

Preliminary analyses were conducted to determine whether statistically significant relations existed among pertinent demographic variables or social desirability (i.e., SDS), and the instruments used to investigate attributional bias (i.e., CAS) and objective countertransference (i.e., IMI-C). Pertinent demographic variables used in preliminary analyses included number of years working as a counseling professional, self-perceived SES level, self-reported income level, highest educational degree received, and licensure status. Because all variables were treated as continuous (via Likert-type scales), Pearson correlations were used to determine whether these variables should be included in the main analyses as covariates. Because 20 separate Pearson correlations were conducted in order to determine whether statistically significant relations existed among pertinent demographic variables or the SDS, and the CAS or IMI-C, a Bonferroni correction was used. The alpha level employed to determine statistical significance were therefore .003 (.05 / 20). Table 2 summarizes these results.
Table 2

Pearson Correlations of CAS, IMI-C Subscales, SDS, and Demographic Variables (N=141)

<table>
<thead>
<tr>
<th></th>
<th>SDS</th>
<th># years in profession</th>
<th>SES level</th>
<th>Income</th>
<th>Years of Education</th>
<th>Type of Licensure</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAS</td>
<td>-.08</td>
<td>.09</td>
<td>.12</td>
<td>.09</td>
<td>-.06</td>
<td>-.07</td>
</tr>
<tr>
<td>IMI-C</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dominant</td>
<td>-.01</td>
<td>.07</td>
<td>-.06</td>
<td>-.13</td>
<td>-.18*</td>
<td>-.04</td>
</tr>
<tr>
<td>Hostile</td>
<td>.09</td>
<td>-.09</td>
<td>-.13</td>
<td>-.09</td>
<td>-.02</td>
<td>.09</td>
</tr>
<tr>
<td>Submissive</td>
<td>.18*</td>
<td>.00</td>
<td>.01</td>
<td>-.10</td>
<td>-.09</td>
<td>.03</td>
</tr>
<tr>
<td>Friendly</td>
<td>.05</td>
<td>.11</td>
<td>.19*</td>
<td>.04</td>
<td>-.14</td>
<td>-.05</td>
</tr>
</tbody>
</table>

* p<.05

Note: CAS=Clinical Attribution Scale; SDS=Marlowe-Crowne Social Desirability Scale; IMI-C=Impact Message Inventory-Circumplex (IMI-C Subscales=Dominant, Hostile, Submissive, and Friendly)

Clinical Attribution Scale

No statistically significant correlations were found among any of the demographic variables or the SDS, and the CAS. Results for the total sample (N=141) were as follows: CAS and SDS (r = -.08, p > .003); CAS and number of years as a professional (r = .09, p > .003); CAS and SES level (r = .12, p > .003); CAS and income level (r = .09, p > .003); CAS and educational level (r = -.06, p > .003); CAS and licensure status (r = -.07, p > .003). Therefore, it was determined that neither participant demographic characteristics nor social desirability warrant inclusion as covariates when investigating attributional bias in future analyses.

Impact Message Inventory-Circumplex

No statistically significant correlations were found among any of the demographic variables or the SDS, and the four IMI-C subscales. For example, only 3.6% of the
variance in the IMI-C Friendly subscale was accounted for by the participants’ self-perceived SES, only 3.2% of the variance in the IMI-C Dominant subscale was accounted for by the participants’ level of education and only 3.3% of the variance in the IMI-C Submissive subscale was accounted for by SDS scores. Because none of the 24 possible correlations between the IMI-C subscales and demographic variables and the SDS were found to be statistically significant, and none of these correlations accounted for more than 4% of variance in IMI-C scores, it was determined that neither participant demographic characteristics nor social desirability warrant inclusion as covariates when investigating countertransference in future analyses.

Clinical Attribution Scale and Impact Message Inventory-Circumplex

Only one statistically significant correlation was found between the CAS and the four primary IMI-C subscales. The CAS was significantly related to IMI-C Submissive subscale scores ($r = -.18, p < .05$). However, only 3.2% of the shared variance in the CAS and IMI-C Submissive subscale was found. The other three IMI-C subscales (i.e., Dominant, Hostile, Friendly, and Submissive) were not found to have significant relations with the CAS. The findings are as follows: IMI-C Dominant subscale and CAS ($r = -.01, p > .05$), IMI-C Hostile subscale and CAS ($r = -.11, p > .05$), IMI-C Friendly subscale and CAS ($r = -.03, p > .05$). Due to a lack of statistically significant relations among these two scales, and little shared variance between them, it was determined that it was not necessary to include both the CAS and IMI-C together in subsequent inferential (MANOVA) analyses.
Main Inferential Analyses

The following section will discuss the main inferential analyses for hypothesis one, hypothesis two, and the counselor clinical judgment ratings of the client.

Hypothesis One

Null hypothesis one stated that there would be no statistically significant group difference in CAS scores (attributional biases) between counselors reacting to a lower SES client versus a higher SES client. SES was categorized into higher and lower client groupings in order to more clearly differentiate client type. Client SES was differentiated in the written client summary and video script by education (i.e., high school versus graduate degree), occupation (i.e., auto body service staff member versus district manager), income (i.e., $20,000 versus $150,000) and lifestyle characteristics (i.e., hobbies of bowling versus golfing). In the video presentation, client SES was also differentiated by appearance (i.e., unshaven versus shaven, t-shirt and jeans versus suit and tie) and language style. All other content-related information such as family structure (i.e., wife and two kids) and symptomatology (i.e., trouble establishing a social network) remained the same.

Descriptive statistics showed that participants reported similar CAS scores, whether reacting to a higher SES client \( (n = 67) \) or a lower SES client \( (n = 74) \). Those reacting to a higher SES client showed average CAS scores of 51.57 \( (\text{Standard Deviation} = 8.51) \); those reacting to a lower SES client showed average CAS scores of 51.91 \( (\text{Standard Deviation} = 8.04) \). A one-way analysis of variance (ANOVA) was conducted to investigate differences in CAS scores among participants in the higher and lower SES
groups. Results showed no significant main effect between the two groups of participants, $F(1,139) = .06, p = .81$, partial $\eta^2 = 0$. Thus, the type of client participants responded to (i.e., higher SES or lower SES client) did not differentiate participants’ CAS scores. Therefore, null hypothesis one was not rejected.

**Hypothesis Two**

Null hypothesis two stated that there would be no statistically significant group difference in scores on the IMI-C (countertransference reactions) between counselors reacting to a lower SES client versus a higher SES client. Descriptive statistics for the four IMI-C subscales are summarized in Table 3 and the correlations between the subscales are reported in Table 4.

**Table 3**

Descriptive Statistics for the Primary IMI-C Subscales Between Participants Responses to Higher or Lower SES Client Videos

<table>
<thead>
<tr>
<th>IMI-C Subscales</th>
<th>Higher SES Client = 1 Mean</th>
<th>Lower SES Client = 2 Mean</th>
<th>Standard Deviation</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMI-C Dominant</td>
<td>9.90</td>
<td>8.61</td>
<td>2.71</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>2</td>
<td>2.23</td>
<td>74</td>
</tr>
<tr>
<td>IMI-C Submissive</td>
<td>13.42</td>
<td>13.46</td>
<td>3.57</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>2</td>
<td>3.42</td>
<td>74</td>
</tr>
<tr>
<td>IMI-C Friendly</td>
<td>12.96</td>
<td>11.91</td>
<td>3.72</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>2</td>
<td>2.64</td>
<td>74</td>
</tr>
<tr>
<td>IMI-C Hostile</td>
<td>9.85</td>
<td>10.47</td>
<td>2.83</td>
<td>67</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>2</td>
<td>3.48</td>
<td>74</td>
</tr>
</tbody>
</table>
Pearson Correlations between each of the IMI-C subscales revealed that all of the subscales had significant correlations with one another, ranging from $r = .21$ to $r = .42$, however, the shared variance among these pairs ranged from only 4.4% to 17.6%. These numbers fall well below .9, which is recommended as minimum value when considering problems associated with multicollinearity, according to the suggested standards of Tabachnick and Fidell (2001).

According to the IMI-C manual, subscales which are closer to one another should have higher correlations than ones that are farther apart (i.e., Submissive and Friendly; Dominant and Hostile) (Kiesler & Schmidt, 2006). In addition, subscales which are polar-opposite to each other should show high negative correlations approaching -1.0 (i.e., Dominant and Submissive; Hostile and Friendly) (Kiesler & Schmidt). In the present study, the correlation between the Submissive and Friendly subscales was $r = .42$. 

Table 4

Pearson Correlations between the IMI-C Subscales, IMI-C subscales and CAS, and Coefficient Alphas for IMI-C subscales and CAS

<table>
<thead>
<tr>
<th></th>
<th>Coefficient Alpha</th>
<th>IMI-C Dominant</th>
<th>IMI-C Hostile</th>
<th>IMI-C Submissive</th>
<th>IMI-C Friendly</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAS</td>
<td>.81</td>
<td>-.01</td>
<td>-.11</td>
<td>-.18*</td>
<td>-.03</td>
</tr>
<tr>
<td>IMI-C Dominant</td>
<td>.72</td>
<td>--</td>
<td>.25*</td>
<td>.38*</td>
<td>.21*</td>
</tr>
<tr>
<td>IMI-C Hostile</td>
<td>.78</td>
<td>--</td>
<td>--</td>
<td>.34*</td>
<td>-.23*</td>
</tr>
<tr>
<td>IMI-C Submissive</td>
<td>.72</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>.42*</td>
</tr>
<tr>
<td>IMI-C Friendly</td>
<td>.74</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

* $p < .05$

Note: IMI-C = Impact Message Inventory-Circumplex (IMI-C Subscales = Dominant, Hostile, Submissive, and Friendly); CAS = Clinical Attribution Scale
and it was found to be the highest intercorrelation among the subscales, which is consistent with manual specifications. The correlation between the Dominant and Hostile subscales was \( r = .25 \), which was lower than expected according to the manual specifications. In regard to the polar-opposite subscales, a negative correlation was observed between the Hostile and Friendly subscales at \( r = - .23 \), but it was a lower correlation than expected. The correlation of \( r = .38 \) between the Dominant and Submissive subscales in the present study, was not only one of the higher intercorrelations amongst the subscales, but it was also a positive correlation, which contrasts with the expectations of the manual specifications. Overall, the results of the intercorrelations of the IMI-C subscales in the present study have some inconsistencies with the manual specifications.

A study conducted by Hafkenscheid (2003) reported the intercorrelations of the the subscales for a Dutch version of the IMI-C as seen in Table 5. In this study, the highest correlations were found between adjacent octant scales (i.e., Submissive and Friendly; Dominant and Hostile), and negative correlations were found between polar-opposite subscales (i.e., Dominant and Submissive; Hostile and Friendly). The results of the intercorrelations of the IMI-C subscales in this study seem to be consistent with the expectations of the manual specifications. There were some similarities in the intercorrelations between the Dominant and Hostile, Hostile and Submissive, Hostile and Friendly, and the Submissive and Friendly subscales of the Hafkenscheid study compared to the present study. The biggest differences between the two studies related to the Dominant and Submissive subscales and the Dominant and Friendly subscales where the intercorrelations were polar opposite of each other.
Table 5
Intercorrelations of the IMI-C Subscales from Hafkenscheid Study (2003)

<table>
<thead>
<tr>
<th></th>
<th>IMI-C Dominant</th>
<th>IMI-C Hostile</th>
<th>IMI-C Submissive</th>
<th>IMI-C Friendly</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMI-C Dominant</td>
<td>--</td>
<td>.21</td>
<td>-.11</td>
<td>-.05</td>
</tr>
<tr>
<td>IMI-C Hostile</td>
<td>--</td>
<td>--</td>
<td>.25</td>
<td>-.34</td>
</tr>
<tr>
<td>IMI-C Submissive</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>.29</td>
</tr>
<tr>
<td>IMI-C Friendly</td>
<td>--</td>
<td>--</td>
<td>--</td>
<td>--</td>
</tr>
</tbody>
</table>

Note: IMI-C=Impact Message Inventory-Circumplex (IMI-C Subscales=Dominant, Hostile, Submissive, and Friendly)

A one-way MANOVA was conducted to investigate differences in IMI-C scores among participants viewing the higher or lower SES client videos. The main effect for group differences (i.e., higher SES client versus lower SES client) indicated a statistically significant result for the combined dependent variables (consisting of the IMI-C Dominant subscale, IMI-C Hostile subscale, IMI-C Submissive subscale, and IMI-C Friendly subscale), $F(4,136) = 4.21, p = .003$, observed power = .92. Partial $\eta^2 = .11$. This was a medium effect size for the model (Cohen, 1988). Because there was a statistically significant main effect, post hoc analyses were conducted. These results are summarized in Table 6. Univariate ANOVA results indicated that only one of the four dependent variables, IMI-C Dominant subscale, had significantly different scores among participants reacting to a higher versus lower SES client, $F(1, 139) = 9.58, p = .002$. Partial $\eta^2 = .06$. This was a small effect size for the IMI-C Dominant subscale (Cohen, 1988). As shown in Table 3, participants rated the higher SES client ($Mean = 9.90$,
Standard Deviation = 2.71) as being more dominant than the lower SES client
(Means=8.61, Standard Deviation=2.23). Therefore, null hypothesis two was rejected.

Table 6
Post Hoc Tests for the Dependent Variables IMI-C subscales: Dominant, Hostile,
Submissive, and Friendly

<table>
<thead>
<tr>
<th>Dependent Variable</th>
<th>Type III Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
<th>Partial Eta Squared</th>
</tr>
</thead>
<tbody>
<tr>
<td>IMI-C Dominant</td>
<td>58.28</td>
<td>1</td>
<td>58.28</td>
<td>9.58</td>
<td>.002*</td>
<td>.064</td>
</tr>
<tr>
<td>IMI-C Submissive</td>
<td>.06</td>
<td>1</td>
<td>.06</td>
<td>.01</td>
<td>.94</td>
<td>.00</td>
</tr>
<tr>
<td>IMI-C Friendly</td>
<td>38.75</td>
<td>1</td>
<td>38.75</td>
<td>3.79</td>
<td>.05</td>
<td>.03</td>
</tr>
<tr>
<td>IMI-C Hostile</td>
<td>13.61</td>
<td>1</td>
<td>13.61</td>
<td>1.34</td>
<td>.25</td>
<td>.01</td>
</tr>
</tbody>
</table>

* p < .05

Note: IMI-C=Impact Message Inventory-Circumplex (IMI-C subscales=Dominant, Hostile, Submissive,
and Friendly)

Clinical Judgments

In addition to completing the CAS and the IMI-C, participants were also asked to make clinical judgments (see APPENDIX F) about the client they reacted to. They were asked to rate how easy or difficult it would be to work with the client, how likely they thought treatment would be successful with the client, the severity of the client’s presenting problem, and which treatment option would be most appropriate for the client. Descriptive statistics and t-test results for these questions are shown in Table 7 and Table 8, respectively. Results indicated that ratings on the question related to the severity of the client’s problems were significantly different between the participant responses to the two different client SES videos (t = -2.65 [df = 139], p < .05). More mild problems were associated with the higher SES client (Mean = 4.87, Standard Deviation=1.5) and more
severe problems were associated with the lower SES client \((Mean = 5.49, \text{ Standard Deviation} = 1.29)\). These results are consistent with the directional hypotheses of the present study, in that lower SES clients would receive more negative clinical judgments.

Table 7

Descriptive Statistics for Clinical Judgment Questions

<table>
<thead>
<tr>
<th>Clinical Judgment Rating</th>
<th>Higher SES Client=1</th>
<th>Lower SES Client=2</th>
<th>n</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Difficulty</td>
<td>1</td>
<td>67</td>
<td>3.79</td>
<td>1.92</td>
<td>.23</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>74</td>
<td>4.14</td>
<td>1.74</td>
<td>.20</td>
<td></td>
</tr>
<tr>
<td>Tx. Success</td>
<td>1</td>
<td>67</td>
<td>7.07</td>
<td>1.71</td>
<td>.21</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>74</td>
<td>6.77</td>
<td>1.69</td>
<td>.20</td>
<td></td>
</tr>
<tr>
<td>Severity of Problem</td>
<td>1</td>
<td>67</td>
<td>4.87</td>
<td>1.50</td>
<td>.18</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>74</td>
<td>5.49</td>
<td>1.29</td>
<td>.15</td>
<td></td>
</tr>
<tr>
<td>Tx Recommendation</td>
<td>1</td>
<td>67</td>
<td>2.19</td>
<td>.40</td>
<td>.05</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>74</td>
<td>2.26</td>
<td>.50</td>
<td>.06</td>
<td></td>
</tr>
</tbody>
</table>

Table 8

T-Test Results for the Clinical Judgment Questions

<table>
<thead>
<tr>
<th>Clinical Judgment Rating</th>
<th>t</th>
<th>df</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Difficulty</td>
<td>-1.12</td>
<td>139</td>
<td>.27</td>
</tr>
<tr>
<td>Tx. Success</td>
<td>1.06</td>
<td>139</td>
<td>.29</td>
</tr>
<tr>
<td>Severity of Problem</td>
<td>-2.65</td>
<td>139</td>
<td>.01</td>
</tr>
<tr>
<td>Tx Recommendation</td>
<td>-.82</td>
<td>139</td>
<td>.41</td>
</tr>
</tbody>
</table>

Summary of Results

In this chapter, both descriptive and inferential statistics were reported. Results of the preliminary analyses revealed that employing demographic variables and social desirability scores as covariates was not necessary in the main inferential analyses. The main analyses included an analysis of variance (ANOVA) using the CAS as the
dependent variable, and a multivariate analysis of variance (MANOVA) using the four IMI-C subscales as dependent variables. Results showed that null hypothesis one was not rejected. That is, no significant differences were found between the CAS scores (measure of attributional bias) of the participants viewing the higher or lower SES client videos. However, null hypothesis two was rejected because a significant main effect was found between the IMI-C scores (measure of objective countertransference reactions) of participants viewing the higher or lower SES client videos. Post hoc analyses revealed that on the IMI-C Dominant subscale participants had significantly different scores when reacting to a higher versus lower SES client. Participants rated the higher SES client as having more dominant interpersonal behavior characteristics than the lower SES client. Finally, results indicated significant differences in scores related to participant ratings on the severity of the client’s problems among the participants viewing the higher or lower SES client videos. More mild problems were associated with the higher SES client and more severe problems were associated with the lower SES client. A discussion of these results is included in Chapter Five.
CHAPTER V
DISCUSSION

A discussion regarding the results and implications of the present study are presented in this chapter. Chapter five is broken down into four sections: 1) interpretations of statistical results and research comparisons; 2) implications for clinical practice and counselor education and supervision; 3) limitations of the study and recommendations for future research; and, 4) summary of the discussion and implications.

Interpretations of Statistical Results and Research Comparisons

This section discusses the interpretations of statistical results from the present study and the comparison of the results of the present study to previous related research. There are four subsections: information pertaining to hypothesis one, information pertaining to hypothesis two, information related to an exploratory analysis of counselor clinical judgments, and conceptual interpretations of the results.

The purpose of the present study was to examine whether there are differences in how counselors respond cognitively and emotionally to clients of different SES backgrounds. Counselor cognitive and emotional reactions were examined through attributional bias and objective countertransference reactions. Participants in the present study included professional counselors and counselor trainees involved in local, state, and
national professional counseling organizations. A total of 141 professional counselors/trainees completed this survey on an internet survey website.

Hypothesis One: Attributional Bias

This section will provide an overview and interpretation of the statistical results in relation to attributional bias in the current study. It will also compare the results of the current study with past and present research in relation to attributional bias and SES.

Overview and Interpretations of Statistical Results

Hypothesis one stated that there would be no statistically significant group difference in CAS scores (attributional biases) between counselors reacting to a lower SES client versus a higher SES client. This hypothesis was tested by conducting an ANOVA on the CAS scores of the two SES groups. The null hypothesis was not rejected. There were no significant differences on CAS scores found between participant responses to the higher or lower SES client videos. Therefore, no statistical evidence of attributional bias was found among the responses of the two groups of participants examining the higher or lower SES client videos. The average CAS total scores for each set of responses for participants viewing the higher or lower client videos were very close to one another: higher SES client was 51.57 and lower SES client was 51.91. According to anchors described on the CAS, this means that, on average, the two groups of participants answered the questions in a somewhat neutral manner, without much differentiation toward internal or external attributional bias. Thus, in the present study no attributional
bias was found among the responses of participants viewing the higher or lower SES client videos.

It is difficult to compare the results of the present study with previous research because no study has been found to date which has examined attributional bias related to client SES in the mental health field. However, if we compare these results with other forms of attributional bias within the SES research arena (i.e., educational assessments) we find that, contrary to the present study, previous research has found evidence of attributional bias related to lower SES individuals (e.g., Baron, Albright & Malloy, 1995; Charles & Littig, 1982; Darley & Gross, 1983; Mann & Taylor, 1974; Stevens, 1980, 1981).

Past and Present Research Comparisons: Attributional Bias and Socioeconomic Status Research

To date, there are no known studies which have previously examined attributional bias in relation to client SES among mental health professionals in mental health settings. However, several studies have examined attributional bias in relationship to student SES in the educational setting. Two studies which closely resemble the present study in research design are Stevens (1980, 1981) and Darley and Gross (1983) in which participants either read or heard a case description of a child and viewed a videotape of that child. Participants included teachers, school psychologists, parents (Stevens), or graduate students (Darley & Gross). In these studies, participants were asked to rate a child’s ability level and traits (positive or negative characteristics) (Darley & Gross; Stevens). The results of these studies found that more negative behaviors or lower ability
levels were assigned to the lower SES child compared to the higher SES child. These results do not match the findings of the present study, which found no differences in attributional bias between the higher and lower SES client groups. Perhaps the most significant difference between these two prior studies and the present study is the type of attributional measure used. In both the Stevens and Darley and Gross studies, the child’s abilities and skills were rated according to different positive or negative character trait attributions. On the contrary, in the present study participants were asked to make causal explanations for the client’s presenting problems, rather than rating his character or abilities. The differences in these measures could potentially explain the differences in the overall results between the present study and the previous research.

A study by Baron et al. (1995) was very similar to the designs of the Stevens (1980, 1981) and Darley and Gross (1983) studies, except that Baron et al. presented participants with either clear or ambiguous information about the student. They found that when participants were provided with ambiguous information about a student, they rated the child’s ability as higher for the higher SES child. However, when participants received clear information about the student’s academic ability no differences were found according the student’s reported SES level. There are some major differences between the Baron et al. study and the present study. In contrast to the Baron et al. study, when participants, in the present study were presented with ambiguous information regarding the client’s presenting problem (i.e., no specific diagnostic information was provided), no differences were found between the participants viewing the two different SES client videos. In addition, there were differences in how attribution was measured. Baron et al.
measured attributional trait and ability ratings, whereas the present study used a causal attributional measure.

In studies by Calhoun (1975) and Mann and Taylor (1974), participants were provided with clear and specific information about the observed individual(s) and then were asked to make causal explanations (internal or external explanations) for the person’s problems/behaviors. In the Calhoun study, the characteristics of the student’s behavior were specifically identified, such as including ratings of the child’s hyperactivity level. In the Mann and Taylor study, participants were given information about an individual, which was reflective of the person as being “friendly-unfriendly, successful-unsuccessful, tolerant-intolerant, brave-cowardly, and considerate-inconsiderate” (p.6). Calhoun reported that race and SES were not found to influence the perceived causes of hyperactivity. Mann and Taylor found that for the English Canadian participants, more negative characteristics were attributed to lower SES individuals. However, the French Canadian participants were found to be more influenced by the individual’s ethnicity, giving more positive attributions towards individuals in the vignettes coming from their own (French Canadian) ethnic group. Although some of the findings of these two studies are similar to the present study (i.e., no attributional bias related to client SES), both the Calhoun and Mann and Taylor studies characterized the observed individual in specific ways compared to the current study, where information about the client was deliberately presented in an ambiguous way.

In summary, the comparison of the results of the present study with previous SES and attributional bias research has shown mixed results. In the many instances, where results of the present study did not match up with previous studies there was a significant
difference in how attributional bias was measured. The present study asked participants
to make direct causal explanations about the client’s problems, whereas several of the
previous studies (Baron et al, 1995; Darley & Gross, 1983; Stevens, 1980, 1981) asked
participants to assess the abilities of the individual or ascribe certain traits to the
individual. Another observation made about several of the previous studies in comparison
to the present study, relates to how information was presented to the participants. In some
of these previous studies (Baron et al., 1995; Calhoun, 1975; Charles & Littig, 1982;
Mann & Taylor, 1974) information about the observed individual was presented in such a
way that clearly identified him or her according to certain positive or negative
characteristics. On the contrary, the present study presented information about the
client’s problems in an ambiguous way.

Hypothesis Two: Objective Countertransference

This section will provide an overview and interpretation of the statistical results in
relation to objective countertransference in the current study. It will also compare the
results of the current study with past and present research in relation to objective
countertransference and client diversity research.

Overview and Interpretations of Statistical Results

Hypothesis two stated that there would be no statistically significant group
difference in scores on the IMI-C (objective countertransference reactions) between
counselors reacting to a lower SES client versus a higher SES client. This hypothesis was
tested by using a one-way MANOVA which compared differences in IMI-C scores on
the four primary subscales (i.e., Dominant, Hostile, Submissive, and Friendly) among participants viewing the higher or lower SES client videos. Statistically significant results were found between the responses of participants viewing the higher or lower SES client videos in the overall IMI-C total scores, leading to a rejection of null hypothesis two. This means that client SES did appear to have an overall impact on counselor objective countertransference reactions.

A post hoc analysis, utilizing univariate ANOVAs, was conducted in order to see which subscales of the IMI-C were impacted by client SES. This analysis found significant differences in scores only associated with the Dominant subscale (IMI-C-D). Participants rated the interpersonal behavior of the higher SES client (average Dominant score 9.9) as evoking feelings of dominance more so than the lower SES client (average Dominant score of 8.61).

The results of hypothesis two are difficult to compare with prior research, considering the lack of research specifically related to client SES and objective countertransference. However, previous research has found evidence of counselor objective countertransference related to client diversity in general (Gelso et al., 1995; Hayes & Gelso, 1993; Milton et al, 2005). Comparison of results found here with those of related prior studies is summarized below.

Past and Present Research Comparisons: Objective Countertransference and Client Diversity Research

Very few studies have empirically examined objective countertransference reactions toward client diversity characteristics (other than specific client diagnoses). In a
study by Milton et al. (2005), researchers conducted a qualitative study of psychotherapists working in gay and lesbian affirmative therapy. Grounded theory was used to identify themes emerging through the interview information. Results of these findings concluded that a therapist’s sexuality can emotionally impact a therapist working with lesbian and gay clients. Participants, who included a combination of psychotherapists and lesbian and gay clients, generally felt that it would be difficult for a heterosexual therapist to overcome countertransference anxieties about homosexual persons. Although the Milton et al. study differs in its research design methodology (qualitative), compared to that of the present study (quantitative), the results of both studies found the presence of objective countertransference reactions between counselors and clients with diverse backgrounds. Aside from the research methodology, the primary difference between the results of these two studies is that the present study identified more specific types of objective countertransference (emotional) impacts that the counselor experienced (i.e., dominance) with the client, than the Milton et al. study.

Hayes and Gelso (1993) conducted a quantitative study in examining male counselor reactions toward gay and HIV-infected clients. Similar to the current study, participants in the Hayes and Gelso study viewed video client simulations. Participants’ level of anxiety and homophobia were measured on a 31 item scale. Male counselors were found to experience greater discomfort with HIV-positive clients, and counselors’ level of homophobia predicted their discomfort with gay clients than with heterosexual clients. In comparison to the present study, the results are similar in that client diversity seemed to have impact on the objective countertransference reactions of the counselors. However, the Hayes and Gelso study only examined counselor countertransference in
terms of counselor level of anxiety and homophobia, but the specifics of the anxiety and phobic reactions were not identified. In the present study, the results found that participants not only experienced more objective countertransference reactions to the higher SES client, but they also identified how, specifically, they were interpersonally impacted by the higher SES client (i.e., dominant reactions).

In a study by Gelso et al. (1995) male and female countertransference reactions toward lesbian and heterosexual female clients were examined. Participant responses to client video simulations were measured using the Daly’s Attitude Scale, Countertransference Factors Inventory (CFI), and the State-Trait Anxiety Inventory. The results of a MANOVA found no differences with sexual orientation and countertransference reactions of the participants. However, it was found that the greater homophobia of the participant lead to heightened avoidance behavior. The results also showed that female participants had greater difficulty recalling the video of the lesbian client than the male participants. Although countertransference was not found to be influenced by the factor of sexual orientation, other reactions were found among the participants. The countertransference measure, CFI, used in the Gelso et al. study focused on the aspect of how countertransference is managed within the counselor (i.e., empathic ability, anxiety management, self-integration, self-insight, and conceptualizing skills). This measure is significantly different than the measure used in the present study, the IMI-C, which measured the type of interpersonal impact the client had on the counselor’s emotions. This difference in the type of countertransference measurement may explain the differences in results between the present study and the Gelso et al. study.
In a study by Waldron et al. (1997), the SES backgrounds of couples were examined in relation to counselor defensiveness during the process of marital therapy and the outcome for the couple receiving therapy. Counselor defensive behavior was measured using a qualitative based Defensive and Supportive Communication coding system for the observed sessions. Results of the present study found that SES did not predict counselor defensive behavior or the outcome of marital therapy for the couple. These results differ from the results of the present study in that the presence of objective countertransference was found in relationship to client SES. These differences might be explained by the type of research design used by Waldron et al., which used a qualitative process to code real observations of couples in marital therapy sessions, versus the use of a simulated client used in the present study.

In summary, the results of the previous countertransference studies offer some support for the findings of the present study. In most cases, these previous studies found that counselors had some type of emotional reaction (i.e., anxiety, phobia) to clients with specific diversity characteristics (Gelso et al., 1995; Hayes & Gelso, 1993; Milton et al., 2005), similar to the present study, which found the presence of objective countertransference reactions for counselors observing the higher SES client. Some of these previous countertransference studies are similar, in methodology, to the current study, utilizing client video simulations (Gelso et al., 1995; Hayes & Gelso, 1993). Perhaps the biggest difference among these previous studies relates to the measurement of countertransference. Many of the previous studies found evidence of general characteristics related to countertransference reactions, through the measurement of anxiety or phobia, but the more specific characteristics of the interpersonal reactions of
the counselor toward client were not measured. The present study not only found evidence of objective countertransference reactions, but was able to identify what type emotional/interpersonal impact (i.e., dominance) the client had on the counselor.

Exploratory Analysis: Clinical Judgment Ratings

This section will provide an overview and interpretation of the statistical results in relation to the clinical judgment ratings in the current study. It will also compare the results of the current study with past and present research in relation to clinical judgments and SES.

Overview and Interpretations of Statistical Results

An additional exploratory analysis of counselor clinical judgments was conducted in the present study which utilized a series of t-tests. This was done in order to examine the relationship between clinical judgment ratings made by participants in the higher versus lower SES client groups. Participants were asked to rate how easy or difficult it would be to work with the client they viewed, how likely they thought treatment would be successful with the client, the severity of the client’s presenting problem, and which treatment option would be most appropriate for the client. These questions (i.e., prognosis, diagnosis, and treatment plan) were similar to the types of clinical judgment ratings used in previous studies on clinical judgment bias (Lopez, 1989). There was no statistical significance found for participant responses to the higher SES or lower SES client videos related to their ratings of client difficulty and predicted treatment success. However, statistically significant results were found for participant clinical judgments of
client problem severity between those participants viewing the higher SES or lower SES client videos. More mild problems were associated with the higher SES client (Mean = 4.87, Standard Deviation = 1.50) and more severe problems were associated with the lower SES client (Mean = 5.49, Standard Deviation = 1.29). These results are consistent with the general hypotheses of the present study, in that lower SES clients would receive more negative clinical judgments. They are also consistent with the findings of previous research, which also found evidence specifically related to the rating of greater pathology for lower SES clients (e.g., DiNardo, 1975; Lee and Temerlin, 1970; Trachtman, 1971).

Past and Present Research Comparisons: Clinical Judgments and Client Socioeconomic Status Research

The present study found some evidence of clinical judgment bias in which participants rated the client’s severity of problem higher for the lower SES client than for the higher SES client. The results of clinical judgment bias in this research study do seem to parallel some of the previous research related to clinical judgment bias and client SES. The results reported here are consistent with findings of similar studies conducted in the 1960’s and 1970’s, which concluded that negative clinical judgment bias was found for lower SES clients (Abramowitz & Dokeycki, 1977). The results of the present study also compare with the findings of Trachtman (1971), DiNardo (1975), Lee and Temerlin (1970), which also found evidence specifically related to the rating of greater pathology for low SES clients.

It is important to note that although some significant findings were found related to participant ratings of the severity of the client’s problem, there were no statistically
significant findings related to the participant ratings for the degree of difficulty working with the client and predicted treatment success. These findings of no statistical significance can also be compared with the results of the CAS Scores, where no statistical significance was found in participant responses related to attributional bias. Both the clinical judgments and counselor attributions represent different areas of a counselor’s cognitive assessment of a client. In previous clinical judgment bias research, counselor clinical judgments have included diagnosis, prognosis, and treatment recommendations (Garb, 1997). The present study attempted to add on to these types of clinical judgments by including a counselor’s attributions for the cause of a client’s behavior and problems. Therefore, it is significant to point out that most of the participants’ responses related to cognitive judgments of the client were not found to be statistically significant.

The findings related to clinical judgments and attributional bias in the present study compare to the results with previous clinical judgment bias studies which did not find overwhelming evidence of clinician bias. In the Bamgbose et al. (1980) study, 61 clinical psychologists read the written case summaries of real clients and rated the clients according to diagnosis, severity of presenting problem, and client disposition. No bias was found in participant’s judgments of the clients in relation to the variables of client race or social class. Umbenhauer and DeWitte (1978) surveyed 527 psychiatrists, psychologists, social workers, and other mental health professionals who were asked to read a written client case history. Participants made clinical judgments of the client according to diagnosis, prognosis, and treatment. Although they found that, overall, more favorable judgments were made for the upper class clients over the lower class clients, the differences related to clinician judgments related to the degree of disturbance,
motivation for change and impulse control of the clients were not significant between the
two classes.

In the Settin and Bramel (1981) study, 418 clinical psychologists reviewed a
written client case history and rated the client according to usefulness of the intervention,
prognosis, interest in providing intervention, comfort on initial contact, client likeability,
client competency, client warmth, client’s level of activity, client strength, and client
understandability. The results of a MANOVA found no significant main effects for social
class in general. However, there was a social class by gender interaction main effect,
which demonstrated that the higher the social class of a male client the more favorable a
therapist’s attitude, while the lower the social class of a female client the more favorable
a therapist’s attitude.

In summary, the results of these three studies (Bamgbose et al., 1980; Settin &
Bramel, 1981; and Umbenhauer & DeWitte, 1978) which found no strong evidence of
clinician bias related to clinician clinical judgment and client SES background are similar
to the results of the present study. It is also interesting to note, that two of these studies
(Settin & Bramel; Umbenhauer & DeWitte) utilized a survey method and had a higher
volume of participants compared to other clinical bias research which had found evidence
of bias but had smaller sample sizes in the range of 40 to 60 participants (Lee &
Temerlin, 1970; DiNardo, 1975). The present study also utilized a survey method and had
more of mid-range sample size (N=141).
Conceptual Interpretation of Results

This section will provide a conceptual interpretation of the results from the current study in relation to attributional theories, objective countertransference theories, and clinical judgment theories.

Attributional Theories

In the present study, the relationship between client SES and counselor attributional bias was investigated. Following the style of an analogue research design, participants viewed a video simulation of a higher or lower SES client. The two video simulations differed according to client occupation, reported income levels, leisure activities, dress, and language style. The CAS was used to measure dispositional and situational attributional bias of the participants. The results of the present study found no significant differences between the two SES client groups. These results are surprising considering similar studies in the academic setting did find evidence of attributional bias related to an individual’s SES. However, a comparison of the present study to these previous SES attributional studies found differences related to the following areas: (1) the measurement of attributional bias; and, (2) the level of ambiguity in the presentation of information about the observed individual to the participants.

Compared to the previous SES attributional studies, the present study appeared to measure attributional bias in a more direct manner. It seems participants were asked to make overt causal explanations for the client’s problems. For example, participants were asked to rate the client on how strongly they felt “…the person is to blame for the difficulties he created for himself” (Chen et al., 1997). This kind of statement seems very
bold, in that it forces the participant to make a direct attributional assignment of the client’s problems. One might suggest that to some degree the participants are essentially being asked the question: Do you think the client is to blame for his problems or his life situation? Perhaps, in the current study, participants answered neutrally because they felt that they had too little information from a four minute video-clip to make such a sweeping generalization of the client. This hypothesis would be interesting and potentially helpful if tested empirically.

In previous studies participants were not necessarily asked to pigeon-hole the observed individual, rather they were asked to rate the individual according to certain traits or skills (Baron et al., 1995; Darley & Gross, 1983; Stevens, 1980, 1981). For example, in the Darley and Gross study, participants rated the child across the following five categories of characteristics: work habit, motivation, sociability, emotional maturity, and cognitive skill. In this case, participants were not necessarily confronted with direct attributional assignment, but were simply asked to assign certain traits or skills to the individual. Another study, conducted by Cozzarelli et al. (2001), used a measure which included 22 factors associated with SES attributions which were then later factor analyzed into three categories: external attributions, internal attributions, and cultural attributions. In this way, participants were able to identify characteristics of an individual/population without necessarily being aware of the types of attributions to which they belonged. Therefore, one hypothesis is that the results would have been different for the current study had participants been asked to rate the client across different character traits or abilities, which had roots in dispositional and situational attributions, rather than being confronted with direct attributional assignments.
Another noticeable difference between the present study and other previous SES attributional studies, relates to the presentation of client information. The present study deliberately attempted to present the client in a somewhat neutral and ambiguous way. However, other previous studies in this area presented participants with a client profile identified as having certain positive or negative characteristics or ability levels and then asked participants to rate the causal attributions of the individual’s success (Baron et al., 1995; Calhoun, 1975; Charles & Littig, 1982; Mann & Taylor, 1974). In fact, Baron et al. found significant differences between how information was presented, clearly versus ambiguously, and participant attributions of the observed individual. These findings point out the important consideration of how information is presented to participants about the observed individual. In the present study, not only was information presented in a somewhat ambiguous way, but then participants were asked to make very direct judgments about the causal nature of the client’s problems. One hypothesis could be that the combination of these two factors influenced participant reactions leading to non-significant results for attributional biases in the present study.

In summary, there are two important considerations related to the non-significant findings of the present study. It is suggested that not only should the manner in which attributional bias is measured be considered, but also how that measure works with how information is presented (i.e., ambiguously or unambiguously) about the client.

*Objective Countertransference Theories*

In the present study, objective countertransference reactions of counselors were investigated in relation to a client’s SES background. The results of the present study
found that counselors not only experienced objective countertransference reactions to the client’s SES background, but more specifically, they had dominant reactions to the higher SES client. These results support the theory of objective countertransference, which suggests that a counselor can experience an evoked or elicited response to certain client behaviors, which would parallel the responses of other typical counselors in similar circumstances (Kiesler, 2001; Schwartz et al., 2007). In the present study, the results of the IMI-C showed that client SES did appear to evoke objective countertransference, or emotional reactions, from the participants.

Not only was the presence of objective countertransference found in counselor responses in the present study, but a specific type of interpersonal impact that the client had on the participants was also found. Several previous countertransference studies, focusing on client diversity issues, measured countertransference in terms of anxiety or phobia of the participants (Gelso et al., 1995; Hayes & Gelso, 1993; Milton et al, 2005). However, through the use of the IMI-C, the present study was able to identify which types of interpersonal characteristics client SES elicited from the participants. Results of the present study found that participants were emotionally impacted in a dominant way (i.e., feeling bossed around, etc.) to the higher SES client. This means that participants felt that the interpersonal behaviors of the higher SES client gave them the impression that he had the tendency “lead, direct, influence, and control others” (Kiesler & Schmidt, 2006, p. 40). These dominant-type characteristics associated with the higher SES client appear to have support in the literature in relationship to stereotypes of higher SES individuals.
The terms ‘power and influence’ are often spoken in conjunction with successful businessmen in American society, such as with famous individuals like Donald Trump. In the literature, stereotypes of higher SES individuals have been described as being focused on individualism, possessing a personal drive, intelligent, ambitious, industrious, working hard, and having initiative (Bullock, 1995; see Weeks & Lupfer, 2004). In his book, *Habits of the Heart*, Robert Bellah (1985) describes the themes related to the cultural identity of American life. He suggests that one character-type that is present in American industrial life is that of the “professional manager” (p. 45). The role of the professional manager is characterized as having the ability to “…persuade, inspire, manipulate, cajole, and intimidate those he manages so that his organization measures up…” (p. 45). These characteristics of the professional manager very closely parallel the dominant characteristics that the counselors in the present study had associated with the higher SES client. They also seem to contain certain underlying value associations.

The focus on individualism and personal initiative are values associated with the Protestant Work Ethic, which have been used to describe American identity (Bullock, 1995; Cokley et al., 2007; Liu, 2001). Sue and Sue (2003) have suggested that our value systems influence how we perceive control and responsibility in our lives. They suggest that the values which best describe the White and middle-class cultural philosophy in America emphasize the values of internal locus of control (IC) and internal locus of responsibility (IR) (Sue & Sue). These values seem to parallel the findings of the present study in which participants felt that the higher SES client was giving the impression of leading and controlling others. Based on the results of the present study, it cannot be determined whether counselor objective countertransference reactions toward
the client of higher SES background affected their view of the client in a positive or negative way. However, regardless of the viewpoint, one could hypothesize that attitudes stemming from countertransference reactions relative to client SES can influence counselors’ perceptions of clients, and therefore influence the process of counseling (Javier & Herron, 2002).

Clinical Judgment Bias Theories

The present study not only examined attributional bias and objective countertransference reactions of counselors related to counselor SES, but it also incorporated some prognostic measures consistent with the traditional research models of previous SES clinical judgment bias studies (Garb, 1997). The results of the present study showed that the severity of the lower SES client’s problems was rated as more severe than the higher SES client. This negative clinical judgment for the lower SES client is consistent with previous research in this area (DiNardo, 1975; Lee and Temerlin, 1970; Trachtman, 1971). The present study, however, extended the focus of traditional SES clinical judgment bias studies by not only examining the clinical judgments of counselors, but also including the cognitive and emotional reactions of counselors. The results indicated that not only was there negative clinical judgment bias toward the lower SES client, but there was also evidence of counselors having a strong objective countertransference reaction toward the higher SES client. These results have significant implications for the practice of professional counselors.
Implications for Clinical Practice and Counselor Education and Supervision

This section describes the implications that the present study has for the clinical practice for professional counselors and the education and supervision of professional counselors.

Implications for the Clinical Practice of Professional Counselors

Bias during the assessment, evaluation, and treatment process is a major concern for the profession of counseling. For example, in *The American Counseling Association Encyclopedia of Counseling* test, response, examiner, interpretive, situational, and ecological biases are highlighted as areas that practitioners must be attuned to throughout their careers (Adams, 2009). Countertransference is also described as a common factor influencing counselors’ work with clients (Pillay, 2009). The results of the present study indicated that as a client diversity characteristic, SES can have an impact on the clinical judgments and objective countertransference reactions of professional counselors. These judgments and objective countertransference reactions can influence how counselors make treatment decisions for the client and also influence the process of therapy. With the infusion of multicultural counseling principles into clinical practice, counselors are encouraged to be aware of the differences between themselves and their clients.

The results of the present study highlight the importance for counselors to consider the influence of their own objective countertransference on the counseling process. In the present study, client SES had a significant impact on counselors’ emotional reactions to the client. Counselor emotions were elicited from a higher SES client, whereby the client was felt as having dominant type interpersonal behaviors.
These results highlight the need for counselors to consider that client diversity characteristics, such as SES, can influence counselor objective countertransference. In general, it is important for counselors to consider the influence of objective countertransference, as it is suggested that unrecognized counselor objective countertransference can negatively impact the course of counseling in unanticipated ways (Kiesler, 2001). Counselors who do learn to recognize their feelings of countertransference are encouraged to attend to those feelings in the therapeutic process and use them as an opportunity to advance the therapy process (Kiesler).

It is important for counselors in clinical practice to consider that value differences between counselor and client can have a significant impact on the process of therapy (Sue & Sue, 2003). The results of the present study found counselors had objective countertransference reactions to the higher SES client, assigning him with dominant interpersonal characteristics. These dominant type characteristics are consistent with the description of the “professional manager” character type in American society (Bellah, 1985). The values underlying this character type represent individualism and a focus on personal initiative, values typically associated with middle-upper SES American society (Sue and Sue, 2003). The philosophy that one’s success is dependent on one’s own ability and hard work can significantly impact counselor attitudes towards their clients (Javier & Herron, 2002; Liu, 2001). The results of the present study highlight the importance for counselors to consider SES as a part of one’s cultural identity and value system. More specifically, counselors must consider their own SES values and how those values might compare with their clients own SES backgrounds. A failure to do this could result in
counselors using treatment approaches that are inappropriate or incompatible with the
SES values of the client.

According to the *Multicultural Counseling Competencies* of the Association for
Multicultural Counseling and Development, counselors must constantly seek to
understand themselves as racial and cultural beings, and develop a cultural self-awareness
and sensitivity of their own cultural heritages (Association for Multicultural Counseling
and Development (AMCD), 2009). In response to the need for counselors to better
understand their own values associated with SES, Liu et al. (2004) have developed a
schema called the Social Class Worldview Model. Although this model is still theory
based, Liu et al. (2004) have begun the process in developing a framework for helping
individuals to begin to identify their own social class identities. The main domains of this
social class model include: Consciousness, Attitudes, and Saliency; Referent Groups;
Property Relationship; Lifestyle; and Behaviors. These five domains help individuals
examine their level of awareness of their social class, their attitudes associated with their
social class, and the meaningfulness that their social class group provides to them. It also
helps individuals examine what social groups they choose to belong to, what types of
material things they value, how they choose to live, and how they behave within the
context of their social environments. By applying the concepts of this SCWM, counselors
can better understand their own social class origins, the social class groups they most
identify with, and the values associated with their chosen social class identities. In the
same way, counselors can also use this model with their clients to help clients identify
their own SES identity and the values associated with their own SES identity.
Counselors in clinical practice must also consider that stereotypes can have negative evaluative implications and behavioral consequences (Fiske, 1993). In the present study, counselors made stereotypic judgments of the client based on the client’s SES background. Even though the information about the client’s presenting problem was presented in an ambiguous way, the severity of the client’s problem was rated more severe for the lower SES client than for the higher SES client. These results show that counselors must use caution in making judgments about their clients when they have limited information. If the stereotypes are inaccurate it could lead to improper treatment plans or cause counselors to socialize clients into accepting potentially dysfunctional views of themselves and their problems (Karuza et al., 1982).

Among their proposed recommendations for reducing classist prejudice against people of lower SES among mental health professionals, Bullock and Lott (2001) suggested that more should be done to explore the applications of intergroup contact and/or implicit and explicit attitude change. The theory behind intergroup contact suggests that contact between two different groups (i.e., SES groups, racial groups) under “optimal conditions” could help to reduce group prejudice (Pettigrew & Tropp, 2006). The suggested prerequisite conditions under which these two groups have contact include things such as: equal status, cooperative interdependence, common goals, supportive norms, personal interaction, and friendship opportunities.

Counselors can get involved in this type of intergroup contact with the lower SES population by becoming involved in advocacy opportunities which seek to assist lower SES individuals and families. In fact, the American Psychological Association has outlined certain advocacy opportunities for mental health professionals in their
Resolution on Poverty and Socioeconomic Status (American Psychological Association (APA), 2000). Some examples of these advocacy opportunities include the support of public policy which seeks to improve the quality of conditions for lower SES individuals and families in the areas of early childhood education, public school education, and post-secondary education and training, providing access to family-friendly jobs, improved health-care coverage, and early intervention and prevention for vulnerable children and families (APA, 2000). Counselor involvement in these areas not only highlights the need for counselors to be aware of SES as an important component to cultural identity, but it also draws attention to the multiple roles and responsibilities of a multicultural counselor. Among their many recommendations for more research related to multicultural competency, Pope-Davis, Liu, Toporek, and Brittan-Powell (2001) suggest that being a multicultural counselor involves other nontraditional roles such as being an advocate or a change agent. Therefore, it may not be sufficient enough to learn more about client differences, but counselors may have to take an active role in making societal changes in order to improve the life conditions for certain client populations.

It is important to point out that although the present study showed some significant findings in the areas related to objective countertransference and clinical judgments, the effect sizes were small. On the IMI-C, although participants rated the higher SES client as impacting them in a dominant way, the effect size for this statistical difference was small ($\text{Partial } \eta^2 = 0.06$). In regard to the clinical judgments, although participant ratings for the severity of the client’s problems were found to be statistically significant, the difference between the mean scores for participant responses to the higher SES client and the lower SES client was only 0.62. This number means that participants
were answering more in a neutral way in regard to client problem severity, without much extreme in response (i.e., higher problem severity versus lower problem severity). Therefore, even though there were statistically significant differences found in counselor reactions (i.e., objective countertransference and clinical judgments) to the higher or lower SES client, the practical and clinical meaning of these differences must be considered.

Based on the strength and practical significance of these findings, counselors should not necessarily enact radical changes in their counseling procedures. Rather, counselors should use these findings as starting point for evaluating the success of their clinical practice with clients from different SES backgrounds. In addition, the small effects sizes point out that there are other, as yet untested, variables that can impact counselor objective countertransference and clinical judgments. Overall, the findings from the present study, significant and not, make a convincing case for the advancement of research related to client SES and counselor cognitive and emotional reactions.

Implications for Counselor Education and Supervision

The results of the present study have implications for the education and supervision of professional counselors related to client diversity. The present study found that a client’s SES background can impact counselor emotions and influence the types of clinical judgments counselors make about their clients. The present study highlights important issues related to counselor objective countertransference. The results of the present study found that counselors can experience emotional reactions to a client’s SES background, which also influenced how the counselors perceived the client’s
interpersonal behavior style. These results show that certain client characteristics, such as SES, can evoke certain emotional reactions within counselors and impact how they view their clients. Counselor educators have suggested that it is important for counselors to learn to recognize their own countertransference reactions to clients, because those reactions can impact the course of therapy (Corey, 2005). Counselor educators and supervisors should not only teach counselor trainees about the potential for objective countertransference to occur in a therapy session, but also to recognize when certain counselor emotions or feelings can be evoked by certain types of clients (Schwartz et al., 2007). Through the results of the present study, counselor educators and supervisors can also educate counselor trainees about how client diversity characteristics such as SES can trigger objective countertransference reactions in the therapy process.

Traditionally, SES has been overlooked as an important aspect of client diversity in counselor multicultural education (Liu, Ali, et al., 2004). Counselor educators and supervisors can use the information from the present study to help counselor trainees become more aware of their own values associated with SES. Specifically, the present study found that counselors tended to assign dominant characteristics to the higher SES client. Whether these characteristics, and the values they represent, are seen positively or negatively, the meanings attached to them that can impact how counselors view clients from different SES backgrounds. For example, counselors who hold values associated with individual responsibility may view their clients as being responsible for all of their problems, when some clients may feel that their problems are related to external factors. This scenario could impact the type of treatment approach a counselor uses for the client and ultimately affect the course of therapy. Counselor educators and supervisors can
assist counselor trainees to not only learn to identify their own SES values, but understand in what ways those values can influence the course of therapy with their clients.

Methods in which counselor educators and supervisors can assist counselor trainees in understanding their values associated with SES include the use of the Social Class Worldview Model. As mentioned above, the Social Class Worldview Model provides a framework for which to understand one’s own SES identity and the values associated with it. Counselor educators and supervisors can have counselor trainees use this model on their own lives in order to help them gain a better understanding of the influence that SES has on their values and lifestyle and how they might influence their own counseling approach. In addition, counselor educators and supervisors can also discuss the types of SES values traditionally associated with “white, middle-class” therapeutic approaches, such as the emphasis on one’s ability to control their own problems and the focus on personal responsibility for those problems (Sue & Sue, 2003).

The incorporation of more minority faculty members or role models into counselor education programs can also be a valuable experience for counselor trainees in learning more about non-traditional therapeutic approaches and value systems first-hand from those who are teaching them (Pope-Davis et al., 2001).

Counselor education and supervision can improve counselor competency in the area of SES by including SES as a client diversity variable in counselor multicultural education. In relationship to the lower SES client population, the curricula of counselor education and training can bring more attention to the causes and impact of poverty and the psychological needs of lower SES individuals and families (APA, 2000). Counselor
educators and supervisors can provide counselor trainees the opportunity to apply their skills and knowledge related to SES considerations, by utilizing case study examples which include clients from different SES backgrounds (Liu et al., 2007).

Limitations and Recommendations for Future Research

This section will identify key limitations of this research study, and will make recommendations for future research related to: limitations related to the constructs of SES, objective countertransference, and attributional bias, internet survey design, measurement and presentation of client information, and client SES video presentations.

Limitations Related to the Constructs of Socioeconomic Status, Attributional Bias, and Objective Countertransference

This section will discuss limitations related to the constructs of SES, attributional bias, and objective countertransference as operationalized in the current study.

Socioeconomic Status

In the present study, an attempt was made to portray a client coming from a high or low SES background using objective indices such as occupation, income level, and educational background. An attempt was also made to dichotomize the high and low SES client characterizations by changing client appearance and language/speaking style. For the purposes of the present study, the concept of SES was defined separately from social class for the primary purpose that SES could be measured in a quantitative manner. However, it is important to consider that the subjective elements related to the concept of
social class may not be able to be effectively separated from the objective aspects of SES. One’s perception of another’s SES identity can include many subjective elements even those we define as “objective” (Liu, Ali, et al., 2004). For example, what may be considered a high SES income to one person, may have a different SES meaning to someone else. Therefore, the client presentations may not have achieved the clear cut dichotomy of a high or low SES client because of the subjective nature of an observer’s interpretation.

**Attributional Bias**

In the present study, counselor attributions of a client’s problems were examined in relation to a client’s SES background. The CAS was used to measure attributional bias because it was the only known tested measure of attributional bias which was designed to measure a person’s attributions of another person. Other previous studies which examined attributional bias had used other forms of measures (i.e., trait lists) which were either not documented/published in the study or their validity and reliabilities were not reported. If one were to examine the CAS in relation to theories of attributional bias, one could conclude that the CAS appears to measure one particular form of attributional bias called fundamental attribution error. Fundamental attribution error takes place when a counselor incorrectly assigns a client’s behavior as stemming from dispositional (i.e., personality characteristics) factors rather than situational factors (i.e., external influences) (Olson et al., 1997). However, fundamental attribution error represents only one form of counselor attributional biases in clinical practice, there are many other types (i.e., actor-observer bias, false-consensus, correspondence bias, defensive attribution, self-serving
bias, illusion of control, false effect, just-world hypothesis, and hindsight bias) (Olson et al., 1997).

Therefore, in the present study, it may be more accurate to say that an attempt was made to examine only one form of attributional bias (i.e., fundamental attributional bias in relation to client SES). Considering the results from the present study, it is not only possible that the CAS was not the best measure for this particular research design, but that it may not have included other forms of attributional bias. It would be interesting for future research to not only consider how attributional bias is measured in relation the research design, but also take into consideration the different forms of attributional bias and how they relate to counselor decision-making relative to client diversity.

**Objective Countertransference**

In the present study, objective countertransference was used as a guiding theory to examine a counselor’s emotional reaction to a client’s SES background. However, client video simulations were used as a means to mimic a real first session with a client. Although counselors viewed the videotape of a simulated client, they did not have the opportunity to interact with the client. Therefore, the theories and concepts of objective countertransference were really applied to a simulated counseling scenario rather than a real counselor-client interaction. This is not the first time client simulations have been used in countertransference studies. Hayes and Gelso (1993) and Gelso et al. (1995) have also used client simulations in their studies of client diversity and counselor countertransference. Nonetheless, an argument can be made that in this present study the theoretical construct of objective countertransference is really assumed rather than being
independently validated. Therefore, future research should consider whether or not similar results would be found with real clients after longer personal contact.

Internet Survey Limitations

The present study was designed as an internet survey. Counselors were contacted via email and invited to participate in the study which was hosted on an internet survey website. The internet survey was chosen for the present study’s research method because it was considered a practical and effective way of targeting and inviting professional counselors and counselor trainees to participate in the present study. However, it is important to note that despite the efforts to target counselors in each region of the United States, it is impossible to determine whether an accurate cross-section of counselors was actually achieved. One explanation for this is due to the open nature (i.e. counselors could forward email invitations to other counselors or others) of the internet survey invitation. Nonetheless, the internet survey proved to be an effective way of drawing participants in from all regions of the United States.

Although there were several benefits to utilizing the internet survey in reaching counselors across the nation, there arose several technical problems. Once the participants agreed to participate, they were asked to read a written case description of the client and then view a four minute video clip of the client. However, electronic survey records show that of the 256 respondents who began the survey, only about 55% (N=141) of them actually completed the survey, and among those who did not complete the survey almost all stopped at the video presentation segment. Therefore, it seemed that the remaining 45% of the participants, who did not complete the survey, experienced some
sort of technical issue related to the video playback on their particular computer or with their specific operating system.

Several hypotheses related to the video viewing problems were that participant computers may have had a slow network connection, that their computers may have blocked the embedded hyperlinks due to having an enabled pop-up blocker, or that their computer did not have the right program to view the streaming video. Participants who did experience problems were provided with the opportunity to actually download the video to their computer, however, this method was time demanding and it is anticipated that few participants took this option.

The technical issues involved with the video playback in the present study may relate to issues with computer literacy of the participants (which was not assessed in the present study). Actually using an on-line survey, in general, may have presented challenges for participants who have limited computer knowledge (Dillman, 2007). Any type of frustration involved with a survey (i.e., video playback) could be enough to stop a participant from completing the entire survey (Dillman). In the present study, there existed an even higher potential for participant frustration because of the complicated nature of the video playback. This factor is highlighted by the evidence of only having a 55% survey completion rate, and the fact that several participants had provided feedback about having difficulty opening the embedded video.

The present study was unique in its design for this particular area of study, by not only using an internet survey method but also by incorporating a streaming video. The use of an online survey has its advantages: it is a quick and cost-effective means to get information (Heppner et al., 1999), and it has the potential to increase sample size and
broaden the scope of the participants. This methodology is promising for future research. Considering the constant change in technology, it is only reasonable to assume that future research consider this methodology and build upon the limitations of the present study and make improvements upon it.

**Client Socioeconomic Status Video Presentation Limitations**

There are some limitations related to the nature of the client video presentations. The results of the present study show differences in countertransference reactions between a higher versus a lower SES client. One hypothesis for this difference may relate to specific presentation variables involved in the higher and lower SES client simulations.

The video simulations were meant to highlight certain stereotypical characteristics associated with a lower or a higher SES client, through not only reported income, occupation, and recreational activities, but also through the aspects of clothing and language. It is possible that participants were influenced by other aspects of the actor’s presentation, beyond the simulated SES factors, such as his voice tone, attractiveness, whether or not he appeared more or less depressed, etc. These types of factors highlight the problems associated with the artificial nature of client video simulations (Heppner et al., 1999). It is recommended that future research consider a more stringent process for validating the client video representations to make sure that they are conveying the characteristics that they are intended to portray. This can be done through a video analysis, incorporating a panel of judges documenting their impressions of the client, and checking for consistencies and inconsistencies among their reviews (Redmond & Slaney, 2002).
The amount of time and the type of exposure the participants had to the client videos may also have impacted their responses. The short length of the client videos (i.e., 4 minutes) may have impacted the manner in which the participants responded versus seeing a real client in a face to face counseling scenario. The use of client simulations has traditionally been a method used in mental health research which avoids the ethical implications of using real counselors and clients (Heppner et al., 1999). However, Pope-Davis et al. (2001) highly recommend the use of real clients and real counseling situations for future multicultural research. They state that it is necessary to have realistic stimuli and relationships and actual experiences of counselors and clients. They suggest that the use of real counseling relationships is not only important for gathering information about the counselor, but also gathering information about the client’s perspective and experience of the counselor. In this regard, multicultural counselor competency is only as good as how the client receives it.

Measurement and Presentation of Client Information Limitations

In the present study, there were no significant findings related to attributional bias. Reasons for this may relate to the type of attributional measurement used, combined with how information was presented, either clearly or ambiguously, to the participants. In the present study, information was presented to participants in a somewhat ambiguous form and then they were asked to determine whether the client’s problems related to his character or personality or whether they related to situational or external factors. Based on the combination of these two factors, one hypothesis could be that participants were unwilling to make specific judgments about the client while having only ambiguous
information. Previous attributional research has found differences between ambiguous
and clear presentations of information about the observed individual (Baron et al., 1995).
In addition, previous attributional bias research has also used character trait descriptions
as a measure of bias (Baron et al, 1995; Darley & Gross, 1983; Stevens, 1980, 1981).
Based on the results of the present study, it is suggested that future research should not
only carefully consider how to present information (i.e., clear or ambiguous) about the
client, but also explore the differences in types of attributional measures and how they
could potentially interact with the presentation of client information.

The results of this study could also have been impacted by the participants’ level
of social desirability in their responses. Although the SDS was used in this study to
measure social desirability, there were no significant findings related to social desirability
on the part of the participants. However, this measure cannot conclude definitively that
social desirability was not present in participant responses. In fact, the participant
population included professional counselors who are trained to be sensitive and culturally
aware of client differences. Therefore, there is the possibility that although the CAS and
most of the IMI-C subscales weren’t’ related to client’s SES background statistically,
participants were hesitant to fully and honestly share their impressions. They have feared
their ratings would be perceived as not being professionally appropriate. One suggestion
for future research in this area would be to use an instrument which can possibly pick up
unintentional forms of bias, such as the Balanced Inventory of Desirable Responding
(BIDR) (Li & Bagger, 2007) for use with populations who may be more culturally
sensitive.
A consideration for future attributional bias research would be to use more qualitative methodologies. Qualitative methodology would allow the researcher to better understand the meaningfulness of a counselor’s actions and examine the contextual elements of the client’s life and problems (Pope-Davis et al., 2001). Relative to SES bias research, qualitative research would provide a better opportunity for researchers to really explore counselor feelings and client perspectives without the restrictions that quantitative measures tend to place on participant responses. Although one drawback of qualitative methodology has traditionally been related to the generalizability of the results, this form of research may provide more insight into the area of attributions and really tap into the meanings and motivations behind each counselor’s attributional response to client diversity (Pope-Davis et al).

Summary

The purpose of the present study was to examine whether there are differences in how counselors respond cognitively and emotionally to clients of different SES backgrounds. Counselor cognitive and emotional reactions were examined through attributional bias and objective countertransference reactions. The results of this found that counselors had objective countertransference reactions toward the higher SES client, characterizing his interpersonal behavior as being dominant. In addition, counselors made more negative clinical judgments toward the lower SES client by judging the lower SES client’s problem more severely than for the higher SES client. No evidence of attributional bias was found in relationship to client SES in the present study, however, the type of measurement mixed with how the information was presented to the
participants may have impacted the results of the present study. Overall, the findings of the present study show us that SES should be considered as an influential aspect of client diversity in the practice of counseling and the education and supervision of counselor trainees. Client SES was not only found to impact a counselor’s emotions, but also the counselor’s judgment of the client. The present study has opened up many opportunities for future research related to the consideration of SES as a part of an individual’s cultural identity, and the impact of SES on the counselor and client relationship and process of therapy, and the influence that objective countertransference can have on the emotions and judgment of the counselor.
REFERENCES


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APPENDICES
APPENDIX A

INFORMED CONSENT

**Project Title:** A national survey of counselor responses to group differences in clients

**Project Coordinator:** Jennifer L. Dougall, doctoral student, Counselor Education and Supervision Program at The University of Akron, Akron, Ohio

**Project Supervisor:** Dr. Robert C. Schwartz, Faculty, Counselor Education and Supervision Program at The University of Akron, Akron, Ohio

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**DESCRIPTION AND EXPLANATION OF PROCEDURES:**
We are conducting a survey of Professional Counselors across the United States. This study will examine how counselors respond to different types of clients. If you agree to participate, you will be asked to complete a brief demographic questionnaire and four additional questionnaires. Questions target the way you think about and feel towards clients. Your participation is voluntary and you may withdraw at any time without penalty.

**RISKS AND DISCOMFORTS:**
There are no known risks associated with completing this survey. This survey is estimated to take approximately 20-30 minutes.

**POTENTIAL BENEFITS:**
As a participant, you will not receive direct benefits from this study, but the data generated from this survey may enhance the training of professional counselors and add to knowledge about training and supervision of mental health professionals.

By clicking the “I Agree” button below, you agree that you understand the procedures and risks/benefits involved in this research. You are free to refuse or to withdraw your consent to participate at any time without penalty or prejudice; your participation is entirely voluntary. Responses collected from you in this study will be anonymous and confidential. Your privacy will be protected because you will not be identified by name as a participant in this project.
Data will be stored in this secured database and locked storage. Confidentiality will be maintained on this website through the use of a Secure Locket Layer (SSL) protocol. However, with any type of internet communication system there may be risk related to the transfer of information from one party to another.

The University of Akron Institutional Review Board, which ensures that research involving people follows federal regulations, has approved the research and this consent form. Questions regarding your rights as a participant in this project can be answered by calling Jennifer L. Dougall at 330-666-2325. Questions regarding the research itself will be answered by Dr. Robert C. Schwartz, Dissertation Chair and Professor, by contacting him at rcs@uakron.edu or 330-972-8155. Any new information that develops during the project will be provided to you if the information might affect your willingness to continue participation in the project.

You may indicate your agreement to participate in the project described by clicking “I Agree” below.
APPENDIX B

DEMOGRAPHIC QUESTIONNAIRE

1. What is your age? _________

2. What is your sex (please check the category that describes you):
   ___ Male
   ___ Female

3. What is your race (please check the one category that best describes you):
   ___ African American/Black
   ___ Euro-American/White
   ___ Asian American/Asian
   ___ Native American
   ___ Hispanic/Latin American
   ___ Other (please list: _________________________)

4. What is your current household income (please check one):
   ___ Less than $25,000
   ___ $25,001-50,000
   ___ $50,001-75,000
   ___ $75,001-100,000
   ___ $100,001+

5. Using the following scale check the response that best describes your own self-perceived Socioeconomic Status (SES):

   1  2  3  4  5  6  7  8  9
   Low  Lower  Middle  Middle  Upper  Upper  Upper

   151
6. What is your relationship status (please check the category that best describes you.):

___ Married/Partnered
___ Divorced/ Separated
___ Widowed
___ Single
___ Living with significant other

7. Total number of years working as a professional counselor:

___ 1-5
___ 6-10
___ 11-15
___ 16-20
___ 21-25
___ 26+

8. Type of licensure received in professional counseling. (Check the response you most identify with.):

___ Licensed Professional Clinical Counselor
___ Licensed Professional Counselor
___ Licensed School Counselor
___ Licensed Marriage and Family Therapist
___ Licensed Psychologist
___ Licensed Addiction Counselor
___ No License

9. Highest degree received to date:

___ Doctorate
___ Master’s
___ Bachelor’s
___ Certificate
___ None
APPENDIX C

WRITTEN CLIENT CASE VIGNETTES

Written Client Case Vignette (High SES)

The client is a married 40 year-old Caucasian male who lives with his wife and two children: a boy who is 10 and a girl who is 7 years old. He has a graduate degree in finance and is employed as a District Manager at a national fortune 500 company. The client reports an annual income of approximately $150,000 and states that his lifestyle is ‘very comfortable.’ He reports having distress related to his family’s recent move from out-of-state. For example, he reports having difficulty settling into their new neighborhood and establishing a social network similar to what he and his family had previously. He indicates that symptoms are disrupting his functioning.

Written Client Case Vignette (Low SES)

The client is a married 40 year-old Caucasian male who lives with his wife and two children: a boy who is 10 and a girl who is 7 years old. He has a high school education and is employed as a ‘service staff’ at a local auto body shop. The client reports an annual income of approximately $20,000 and states that his lifestyle is ‘hard but he gets by.’ He reports having distress related to his family’s recent move from out-of-state. For example, he reports having difficulty settling into their new neighborhood
and establishing a social network similar to what he and his family had previously. He indicates that symptoms are disrupting his functioning.
APPENDIX D

CLINICAL ATTRIBUTION SCALE

<table>
<thead>
<tr>
<th>Identification (4 digit)</th>
<th>Group Number</th>
</tr>
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</table>

Date: ________________

Instructions: In the following section you will find 18 statements about the person you viewed in the taped interview. Please make your judgment of the client on the basis of how you perceive him. Each statement uses a 5-point scale ranging from “Strongly Agree” to “Strongly Disagree”. Check the response that you feel is most appropriate.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Undecided</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
</tr>
</tbody>
</table>

_____ 1. The causes of the person’s problem are something that reflect aspects of the person.

_____ 2. Outside forces influenced the way in which the person acted.

_____ 3. The person’s mood (instability, or lability, etc.) is a major cause of his problem.

_____ 4. Aspects of the person’s personality caused him to behave the way he did.

_____ 5. The cause of the person’s difficulty is primarily related to what was going on around him.

_____ 6. I believe that a lot of the person’s difficulty lies in the situations impinging on him.

(Note: This scale was developed by Mei-whei Chen, Ph.D. For permission to use or other information, please contact M-chen@neiu.edu).
<table>
<thead>
<tr>
<th></th>
<th>1</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Strongly Agree</td>
<td>Agree</td>
<td>Undecided</td>
<td>Disagree</td>
<td>Strongly Disagree</td>
</tr>
</tbody>
</table>

7. In the future, the person’s same problem will probably be present again, with other people and in different situations.

8. Something in the person’s attitude contribute to his problem.

9. Most people would not react the way this person did.

10. Much of the person’s behavior is determined by the parameters of the circumstances in which he is involved.

11. The person’s characteristics (e.g. low self-esteem, emotional problems, or projection…etc.) play a major role in causing his problems.

12. The behaviors of other people caused the person to behave the way he did.

13. I believe that this person is to blame for the difficulties he created for himself.

14. Deficiencies in the person’s personality should be the target of treatment.

15. The person’s behavior might be different if the situation were different.

16. Even an adequate person would have behaved the way the person did if he were in the same situation.

17. Problems arise because of something within the person.

18. The causes of the person’s problem lie in aspects of the events that were taking place.
APPENDIX E

IMPACT MESSAGE INVENTORY-CIRCUMPLEX (BRIEF VERSION)

Instructions: You are to respond to this Inventory by indicating how accurately each of the items describes your reactions to the client.

Read each of the items and click on the response which best describes how you would be feeling and/or would want to behave if you were, at this moment, in this person’s presence.

1 - Not at all 3 - Moderately so
2 - Somewhat 4 - Very much so

If I were working with this client he would make me feel...

1. bossed around. (Dominant subscale sample item.)

If I were working with this client he would make me feel that...

16. I'm going to intrude. (Hostile subscale sample item.)

18. I can ask him to carry his share of the load. (Friendly subscale sample item.)

If I were working with this client it would appear to me that....

25. he thinks I have most of the answers. (Submissive subscale sample item.)

(*Permission granted by Mind Garden, Inc. to only use up to five sample items for dissertation reproduction. The items chosen above are examples from each subscale. It is also important to note that the opening statements were modified from original IMI-C to reflect a counseling scenario. For example, the original statement “When I am with this person he makes me feel...” was modified to “If I were working with this client he would make me feel...”)

IMI-C, © 2006 by Donald J. Kiesler. All Rights Reserved. Published by Mind Garden, Inc., www.mindgarden.com
APPENDIX F

CLINICAL QUESTIONNAIRE

Check the response that best describes how easy/difficult you believe it would be to work with this client clinically (higher scores equal higher degree of difficulty):

<table>
<thead>
<tr>
<th>1</th>
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<th>3</th>
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<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Easy</td>
<td>Somewhat Easy</td>
<td>Unsure</td>
<td>Somewhat Difficult</td>
<td>Very Difficult</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Check the response that best describes how likely you think treatment would be successful with this client (higher scores equal more likely):

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<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very Unlikely</td>
<td>Somewhat Unlikely</td>
<td>Unsure</td>
<td>Somewhat Likely</td>
<td>Very Likely</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Check the response that best describes how you would rate the severity of the client’s presenting problem (higher scores equal equal more symptom severity).

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<tr>
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<th>7</th>
<th>8</th>
<th>9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mild</td>
<td>Severe/Crisis</td>
<td>Moderate Problems</td>
<td>Problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Check the best treatment option that you recommend for this client:

- [ ] brief counseling (1-3 sessions)
- [ ] short-term counseling (4-10 sessions)
- [ ] long-term counseling (10 or more sessions)
- [ ] no treatment is needed
APPENDIX G

THE MARLOWE-CROWNE SOCIAL DESIRABILITY SCALE

(CROWNE & MARLOWE, 1960)

Listed below are a number of statements concerning personal attitudes and traits. Read each item and decide whether the statement is True or False as it pertains to you personally.

1. Before voting I thoroughly investigate the qualifications of all the candidates. True False

2. I never hesitate to go out of my way to help someone in trouble. True False

3. It is sometimes hard for me to go on with my work if I am not encouraged. True False

4. I have never intensely disliked anyone. True False

5. On occasion I have had doubts about my ability to succeed in life. True False

6. I sometimes feel resentful when I don’t get my way. True False

7. I am always careful about my manner of dress. True False

8. My table manners at home are as good as when I eat out in a restaurant. True False

9. If I could get into a movie without paying and be sure I was not seen I would probably do it. True False

10. On a few occasions, I have given up doing something because I thought too little of my ability. True False

11. I like to gossip at times. True False

12. There have been times when I felt like rebelling against people in authority even though I knew they were right. True False

13. No matter who I’m talking to, I’m always a good listener. True False

14. I can remember “playing sick” to get out of something. True False

15. There have been occasions when I took advantage of someone. True False

16. I am always willing to admit it when I make a mistake. True False

17. I always try to practice what I preach. True False
18. I don’t find it particularly difficult to get along with loud
mouthed, obnoxious people. True False
19. I sometimes try to get even rather than forgive and forget. True False
20. When I don’t know something I don’t at all mind
admitting it. True False
21. I am always courteous, even to people who are
disagreeable. True False
22. At times I have really insisted on having things my own
way. True False
23. There have been occasions when I have felt like smashing
things. True False
24. I would never think of letting someone be punished of my
wrongdoings. True False
25. I never resent being asked to return a favor. True False
26. I have never been irked when people expressed ideas
very different from my own. True False
27. I never make a long trip without checking the safety of
my car. True False
28. There have been times when I was quite jealous of the
good fortune of others. True False
29. I have almost never felt the urge to tell someone off. True False
30. I am sometimes irritated by people who ask favors of me. True False
31. I have never felt that I was punished without cause. True False
32. I sometimes think when people have a misfortune they
only got what they deserved. True False
33. I have never deliberately said something that hurt
someone’s feelings. True False
APPENDIX H

SCRIPT GUIDELINES

Low SES Client

Counselor: I want to thank you for coming in. Can you tell me what brought you in today?

Client:
- Can’t sleep.
- Wake-up in the middle of the night and start thinking about things. Can’t go back to sleep.
- Feeling edgy and tired most of the day.
- Feeling like it’s hard to get up and go and do the things I need to do.
- Not motivated
- Wife complaining.
- Not motivated to do things with the kids.
- My wife even says I have been “barking” at her and the kids a lot.
- Problems getting worse over last 1-2 months.

- We moved to this area about 4 months ago from out-of-state to be near family.
- My job is o.k. This body shop runs like the one I worked in before. The people I work with are o.k. guys.
- The house and the area we live in are fine, and are about the same as where we used to live.
- The kids are making friends already and getting along fine in school.

- My wife and I get along well. I can talk to her about anything.
- Lately, though, I feel as though I have been dumping too much on her, you know.
- Where we used to live, I had a couple of buddies I used to do things with.
- I used to kick back with the guys and watch the game.
- I also used to belong to a bowling league at my old job and just hang out with the guys. But now, I don’t even feel like going bowling.
- For some reason, I am having trouble getting to know people in this new neighborhood.
High SES Client

Counselor: I want to thank you for coming in. Can you tell me what brought you in today?

Client:
- I feel terrible.
- I can’t sleep.
- I go to sleep fine, but I always seem to get up in the middle of the night and start rehashing the day in my mind. Then I can’t go to sleep.
- I feel edgy, and tired most of the day.
- I feel like it’s hard for me to get motivated to do anything.
- When I get home from work I don’t want to do much more than sit and relax.
- My wife complains that I have not even been helping out much around the house.
- I have not even felt like doing much with the kids, it just takes a lot out of me.
- My wife even says I have been “barking” at her and the kids a lot.
- Problems getting worse over last 1-2 months.

- We moved to this area about 4 months ago from out-of-state to be near family.
- My transition to the new job has been going well. It is very similar to the one I had before and I get along pretty well with everyone at the office.
- The house and the area we live in are fine, and are about the same as where we used to live.
- The kids are making friends already and getting along fine in school.

- My wife is very supportive and we have a good relationship. I can talk to her about anything.
- Lately, though, I feel as though I have been leaning too much on her.
- Where we used to live, I had a couple of friends I used to do things with and it would help me vent some steam.
- Every week I used to go golfing with them.
- But now, I don’t even feel like golfing or doing much of anything.
- For some reason, I am having trouble getting to know people in this new neighborhood.
APPENDIX I

EVIDENCE OF APPROVAL OF THE INSTITUTIONAL REVIEW BOARD

NOTICE OF APPROVAL

Date: November 7, 2008

To: Jennifer L. Dougall
4740 Tree top Drive
Copley, Ohio 44321

From: Sharon McWhorter, IRB Administrator

Re: IRB Number 20081101
“The Influence of Client Socioeconomic Status on Counselors’ Attributional Biases and Countertransference Reactions”

Thank you for submitting your IRB Application for Review of Research Involving Human Subjects for the referenced project. Your application was approved on November 7, 2008. Your protocol represents minimal risk to subjects and matches the following federal category for exemption:

- Exemption 1 - Research conducted in established or commonly accepted educational settings, involving normal educational practices.
- Exemption 2 - Research involving the use of educational tests, survey procedures, interview procedures, or observation of public behavior.
- Exemption 3 - Research involving the use of educational tests, survey procedures, interview procedures, or observation of public behavior not exempt under category 2, but subjects are elected or appointed public officials or candidates for public office.
- Exemption 4 - Research involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens.
- Exemption 5 - Research and demonstration projects conducted by or subject to the approval of department or agency heads, and which are designed to study, evaluate, or otherwise examine public programs or benefits.
- Exemption 6 - Taste and food quality evaluation and consumer acceptance studies.

Annual continuation applications are not required for exempt projects. If you make changes to the study’s design or procedures that increase the risk to subjects or include activities that do not fall within the approved exemption category, please contact me to discuss whether or not a new application must be submitted. Any such changes or modifications must be reviewed and approved by the IRB prior to implementation.

Please retain this letter for your files. If the research is being conducted for a master’s thesis or doctoral dissertation, the student must file a copy of this letter with the thesis or dissertation.

Cc: Robert C. Schwartz - Advisor
Cc: Stephanie Woods - IRB Chair

Office of Research Services and Sponsored Programs
Akron, OH 44325-2102
330-972-7668 • 330-972-4281 Fax
The University of Akron is an Equal Education and Employment Institution.

Approved consent forms enclosed